

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

JOHN HANCOCK LIFE INSURANCE
COMPANY, JOHN HANCOCK
VARIABLE LIFE INSURANCE
COMPANY and MANULIFE
INSURANCE COMPANY,

Plaintiffs,

v.

ABBOTT LABORATORIES,

Defendant.

CIVIL ACTION NO. 05-11150-DPW

**ABBOTT'S CORRECTED COUNTER DESIGNATIONS FOR JEFFREY
LEIDEN, M.D., Ph.D.**

Defendant Abbott Laboratories ("Abbott") respectfully submits the attached corrected deposition counter-designations for the April 26, 2007 deposition of Jeffrey Leiden, former Senior Vice-President and Chief Scientific Officer, Abbott Laboratories.

Dated: February 22, 2008

Respectfully submitted,

ABBOTT LABORATORIES

By: /s/ Eric J. Lorenzini
Eric J. Lorenzini

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CERTIFICATE OF SERVICE

I hereby certify that this document(s) filed through the ECF system will be sent electronically to the registered participants as identified on the Notice of Electronic Filing (NEF) and paper copies will be sent to those indicated as non registered participants on February 22, 2008.

Date: February 22, 2008.

/s/ Ozge Guzelsu

Jeffrey Leiden Deposition Designations


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Color Key to Deposition Designations

 Designation by Plaintiffs

 Counter Designation by Defendants

 Designation by Defendants

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1 IN THE UNITED STATES DISTRICT COURT
2 FOR THE DISTRICT OF MASSACHUSETTS
3
4 JOHN HANCOCK LIFE INSURANCE)
5 COMPANY, JOHN HANCOCK VARIABLE)
6 LIFE INSURANCE COMPANY, and)
7 MANULIFE INSURANCE COMPANY)
8 (f/k/a INVESTORS PARTNER)
9 INSURANCE COMPANY,)
10 Plaintiffs,)
11 vs.) No. 05-11150-DPW

12 ABBOTT LABORATORIES,)
13 Defendant.)

14 C O N F I D E N T I A L

15 The videotaped deposition of JEFFREY
16 LEIDEN, taken pursuant to the Federal Rules of
17 Civil Procedure of the United States District
18 Courts pertaining to the taking of depositions,
19 taken before JOANNE H. RICHTER, a Notary Public
20 within and for the County of Cook, State of
21 Illinois, and a Certified Shorthand Reporter of
22 said state, No. 84-2082, at Wyndham Glenview
23 Suites, 1400 Milwaukee Avenue, Glenview, Illinois,
24 on the 26th day of April, A.D. 2007, at 8:30 a.m.

1 PRESENT:

2 CHOATE, HALL & STEWART, LLP

3 (Two International Place

4 Boston, Massachusetts 02110

5 617.248.5000), by:

6 MR. BRIAN A. DAVIS,

7 appeared on behalf of the Plaintiffs;

8

9 MUNGER, TOLLES & OLSON, LLP

10 (355 South Grand Avenue, Suite 3500

11 Los Angeles, California 90071

12 213.683.9276), by:

13 MR. JEFFREY I. WEINBERGER,

14 appeared on behalf of the Defendant.

15

16 ALSO PRESENT:

17 MR. PETER N. WITTY and

18 MS. KAREN L. HALE,

19 Counsel, Abbott Laboratories.

20

21 VIDEOGRAPHED BY: WES FRANCE, Legal Videographer.

22

23 REPORTED BY: JOANNE H. RICHTER,

24 C.S.R. No. 84-2082.

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1 Weinberger representing Abbott Laboratories and
2 Dr. Leiden at this deposition.

3 MR. WITTY: Pete Witty representing Abbott
4 Laboratories.

5 MS. HALE: Karen Hale representing Abbott
6 Laboratories.

7 THE VIDEOGRAPHER: Will the reporter now swear
8 in the witness please.

9 (WHEREUPON, the witness was duly
10 sworn.)

11 JEFFREY MARK LEIDEN,
12 called as a witness herein, having been first duly
13 sworn, was examined and testified as follows:

14 EXAMINATION

15 BY MR. DAVIS:

16 Q. Good morning, sir, would you state your
17 name for the record, please.

18 A. Yes, it is Jeffrey Mark Leiden.

19 Q. You are a doctor, correct?

20 A. Yes.

21 Q. And would you like me to refer to you as
22 "Dr. Leiden," is that fair, during the course of
23 the deposition?

24 A. Of course.

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1 Q. We are not trying to make this into a
2 torture test, so if you would like a break at some
3 point in time, please let me know and we will try
4 to accommodate you as soon as possible thereafter.
5 Do you understand that?

6 A. Yes.

7 Q. Sir, where are you currently employed?

8 A. I am an employed as a partner at
9 Clarus Ventures.

10 Q. Where is your business office currently?

11 A. It is in Cambridge, Massachusetts.

12 Q. You don't have any plans to relocate to
13 Massachusetts at this point in time?

14 A. No.

15 Q. How long have you worked at Clarus?

16 A. Since November 1, 2006.

17 Q. At some point in time you were employed
18 by Abbott Laboratories, correct?

19 A. Yes.

20 Q. When were you employed by Abbott?

21 A. Beginning in July of 2000 and ending
22 March 24 of 2006.

23 Q. What positions did you hold at Abbott?

24 A. Senior vice president, chief scientific

1 officer, executive vice president, and president
2 and chief operating officer of pharmaceutical
3 products group.

4 Q. Pharmaceutical products group, that's
5 the portion of Abbott that entered into the deal
6 with John Hancock, is that correct?

7 A. I don't understand the question.

8 MR. WEINBERGER: Objection.

9 MR. DAVIS: Okay.

10 BY MR. DAVIS:

11 Q. You know that this case is about an
12 agreement that Abbott Laboratories signed with John
13 Hancock?

14 A. Yes.

15 Q. You signed that agreement on Abbott's
16 behalf, didn't you?

17 A. I don't recall, but it is possible.

18 Q. Have you seen a copy of that agreement
19 recently?

20 A. No, I haven't.

21 Q. So you don't recall signing that
22 agreement as you sit here today?

23 A. No.

24 Q. You know that that agreement had to do

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1 with the pharmaceuticals division of Abbott?

2 A. You have to restate that question,

3 because there wasn't a pharmaceuticals division of

4 Abbott at the time.

5 Q. What was the business group for which

6 you had responsibility back in 2001?

7 A. When in 2001?

8 Q. In March of 2001.

9 A. I believe in March of 2001 I was

10 executive vice president of the pharmaceutical

11 products group.

12 Q. And did the pharmaceutical products

13 group have any involvement with the deal with

14 John Hancock?

15 A. Yes, the -- yes, it did.

16 Q. How so?

17 A. My remembrance of that deal, although

18 I didn't negotiate it myself, was that it involved

19 John Hancock providing research funding for a

20 series of pharmaceutical products, pipeline

21 products.

22 Q. Products that were within the

23 pharmaceutical products group?

24 A. Yes.

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1 Q. For which you had responsibility?

2 A. Yes.

3 Q. Did you have responsibility for

4 overseeing the negotiation and execution of the

5 agreement with John Hancock?

6 A. No.

7 Q. Who within the pharmaceutical products

8 group had that responsibility?

9 A. The agreement was -- started to be

10 negotiated before I actually arrived at Abbott.

11 I arrived at Abbott in July of 2000. And it was

12 negotiated principally by Arthur Higgins, who at

13 that time was the senior vice president of

14 pharmaceutical products division, called PPD;

15 Jim Tyree, who was in a licensing or business

16 development function within PPD; and I believe

17 John Leonard, who was the head of pharmaceutical

18 products development.

19 Q. As of March 2001, did you report to

20 Mr. Higgins?

21 A. No, he reported to me.

22 Q. So, ultimately, Mr. Higgins, his

23 involvement in the negotiation of that agreement,

24 at that point in time he reported to you, is that

1 A. Subsequently to that.

2 Q. Would you give me just a brief overview

3 of your educational background, please.

4 A. Where do you want me to start?

5 Q. Where did you graduate from high school?

6 A. I didn't graduate from high school.

7 Q. Did you attend high school?

8 A. Yes.

9 Q. You went on to college at some point in

10 point?

11 A. Yes.

12 Q. Without graduating from high school?

13 A. Yes.

14 Q. How did you manage that?

15 A. I am not sure what the question means.

16 I left high school to go to college.

17 Q. Where did you go to college?

18 A. University of Chicago.

19 Q. What year did you graduate?

20 A. 1975.

21 Q. With what degree?

22 A. Bachelor of arts.

23 Q. Did you go on to school from there?

24 A. Yes.

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1 Q. Where?

2 A. I went to do an M.D. and Ph.D. program

3 at the University of Chicago.

4 Q. Did you graduate from that program?

5 A. Yes.

6 Q. When?

7 A. I received my Ph.D. in 1979 and my M.D.

8 in 1981.

9 Q. In what field is your Ph.D.?

10 A. It was formerly in virology and

11 molecular genetics.

12 Q. You attained your M.D. the following

13 year?

14 A. No, I obtained my M.D. in 1981.

15 Q. Did you actually practice as a physician

16 at some point in time?

17 A. Yes.

18 Q. For how long?

19 A. 18 years.

20 Q. In what field, what fields?

21 A. Internal medicine and cardiovascular

22 diseases.

23 Q. Where?

24 A. At the University of Chicago, University

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1 of Michigan, and Harvard Medical School.

2 Q. So did the 18 years begin in 1981 when

3 you graduated from medical school?

4 A. Yes.

5 Q. And that takes us to 1999?

6 A. Yes.

7 Q. And where did you go in 1999?

8 A. Actually it takes us -- I am sorry. It

9 was 19 years. It was 2000 when I left to go to

10 Abbott.

11 Q. Is it fair to say the first job you took

12 in private industry after ceasing to be a

13 practicing physician was with Abbott?

14 A. Yes.

15 Q. And the first job that you took --

16 A. Actually, sorry, let me correct my

17 answer. You said "private industry." Abbott's a

18 public company.

19 Q. Now, the first job that you took with

20 Abbott was senior vice president?

21 A. And chief scientific officer.

22 Q. And your positions changed with Abbott

23 over time?

24 A. Yes.

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1 Q. What did your position -- let me go back
2 a second. As senior vice president and chief
3 scientific officer, what were your primarily duties
4 and responsibilities?

5 A. I was responsible for overseeing and
6 providing advice on scientific programs within
7 Abbott Laboratories across all divisions.

8 Q. When you say "divisions," what
9 divisions?

10 A. Pharmaceutical products division,
11 hospital products division, diagnostics division,
12 Ross nutritional division, and Abbott international
13 division.

14 Q. How long did you hold that position?

15 A. I was chief scientific officer for the
16 entire time I was at Abbott, but I was senior vice
17 president for approximately four months until
18 approximately September of 2000.

19 Q. And the next position you took at that
20 point in time?

21 A. Executive vice president of the
22 pharmaceutical products group.

23 Q. When you say you continued on as chief
24 scientific officer, was that true that you were

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1 chief scientific officer across all divisions?

2 A. Yes.

3 Q. But as executive vice president, you
4 were focused on the pharmaceutical division?

5 A. Yes. Not "division," "pharmaceutical
6 products group." There is a difference.

7 Q. I think you described it earlier as a
8 division of Abbott.

9 A. No. You described it earlier as a
10 division, but actually the way it works is the
11 pharmaceutical products group included
12 pharmaceutical products division, Abbott
13 international, the research and development
14 functions, the manufacturing functions involved
15 with pharmaceutical products.

16 Q. So, if I understand, the pharmaceutical
17 products division is a part of the pharmaceutical
18 products group, but not exactly the same thing?

19 A. Yes.

20 Q. And I just want to make it clear, as
21 well, when you became executive vice president in
22 the fall of 2000 --

23 A. Yes.

24 Q. -- 2000, you were executive vice

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- 1 president of the pharmaceutical products division
- 2 or pharmaceutical products group?
- 3 A. Pharmaceutical products group.
- 4 Q. Who was your immediate superior in that
- 5 position?
- 6 A. Miles White.
- 7 Q. Who is Mr. White?
- 8 A. He is the CEO of Abbott and chairman of
- 9 the board.
- 10 Q. Before you became executive vice
- 11 president, who was your immediate superior?
- 12 A. For three months, it was Bob Parkinson.
- 13 Q. Who was Bob Parkinson?
- 14 A. He was the COO of the Abbott.
- 15 Q. From the time that you took that
- 16 position as executive vice president in the fall of
- 17 2000 until you left Abbott --
- 18 A. Sorry, could I correct it? The fall of
- 19 2000. You said "2002."
- 20 Q. Sorry. From the time that you took the
- 21 position as executive vice president in
- 22 approximately the fall of 2000 until you left
- 23 Abbott in 2006, were you -- was your immediate
- 24 superior Mr. White?

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1 A. Yes.

2 Q. How frequently did you interact with him

3 in that time frame?

4 A. I don't understand the question. It

5 varied considerably from week to week and month to

6 month.

7 Q. What was the range?

8 A. Anywhere from as little as once every

9 week to as much as 50 to 100 times a week.

10 Q. Where was his office physically in

11 comparison to yours?

12 A. It was approximately 30 feet away.

13 Q. And your office was at Abbott Park?

14 A. Yes.

15 Q. Did you ever discuss the John Hancock

16 agreement with Mr. White?

17 A. I am sure I did, but I don't recall the

18 precise discussions.

19 Q. Do you recall anything about your

20 discussions with Mr. White regarding the John

21 Hancock agreement?

22 By the "John Hancock agreement," you

23 understand I am referring to the research funding

24 agreement signed in March of 2001?

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1 told me the only conversations that he remembers
2 had to deal with claims that Hancock asserted and
3 evaluation of those claims with attorneys being
4 present, so they are clearly privileged and I would
5 instruct him not to answer.

6 BY MR. DAVIS:

7 Q. Is that true?

8 A. Yes.

9 Q. Do you have any recollection of any
10 discussions with Mr. White about the John Hancock
11 deal before that deal was executed?

12 A. No.

13 Q. Did Mr. White approve that deal before
14 it was executed?

15 A. I don't recall him approving that deal.

16 MR. DAVIS: Why don't we mark this as the
17 first exhibit.

18 (WHEREUPON, said document was marked

19 Leiden Deposition Exhibit No. 1, for

20 identification, as of 4/26/07.)

21 BY MR. DAVIS:

22 Q. Dr. Leiden, you have what's been marked
23 as Exhibit 1 to your deposition. If you turn to
24 the -- I will identify this for you, and

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1 Mr. Weinberger will point out if I am wrong. This
2 is a copy of the research funding agreement between
3 Abbott Laboratories dated March 13th, 2001.

4 Would you turn to the 35th page of the
5 document, please. The page numbers appear at the
6 top, actually.

7 A. Yes, I see it.

8 Q. Is that your signature?

9 A. Yes.

10 Q. So you did, in fact, sign this document
11 on behalf of Abbott Labs?

12 A. Yes.

13 Q. Now, did you read the document before
14 you signed it?

15 A. No, I don't recall reading it.

16 Q. Do you typically sign documents on
17 behalf of Abbott that you don't read?

18 A. Some documents, yes, when I was provided
19 with information. Some documents I read, or read.

20 Q. Who reviewed this document on Abbott's
21 behalf before you signed it to make sure that the
22 terms were acceptable to Abbott?

23 A. As I said, this document was -- the
24 negotiations were done and the document reviewed by

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1 Arthur Higgins, John Leonard and, I believe,

2 Jim Tyree.

3 Q. Did you come to some understanding of

4 what the terms of the document were before you

5 signed it?

6 A. Yes.

7 Q. And how did you do that?

8 MR. WEINBERGER: If the understanding you came

9 to involved communications with inside Abbott

10 lawyers, then I caution you not to reveal those and

11 I would instruct you not to answer.

12 MR. DAVIS: I am certainly entitled to know

13 what his understanding of the document was

14 regardless of what the source was.

15 MR. WEINBERGER: I don't agree.

16 MR. DAVIS: Then we are going to have to stop

17 the deposition and see if we can get the judge on

18 the phone, because I am entitled to know what his

19 understanding of the agreement was before he signed

20 it.

21 MR. WEINBERGER: You are not entitled to

22 understand what some lawyer told him about that

23 lawyer's understanding of the agreement, so if you

24 phrase your question -- let me finish. If you

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1 MR. DAVIS: I think the record is going to
2 speak for itself here.

3 MR. WEINBERGER: It sure is.

4 BY MR. DAVIS:

5 Q. Dr. Leiden, did you form an
6 understanding of the agreement before you signed
7 it?

8 A. I don't remember signing it, but I had
9 an understanding of the agreement.

10 Q. Okay. What was your understanding of
11 the agreement?

12 A. That the agreement called for John
13 Hancock to provide approximately \$200 million of
14 funding for a basket of Abbott pipeline assets in
15 return for a future royalty arrangement.

16 Q. You understood that Hancock's obligation
17 to provide up to 200 million was contingent upon
18 how the various compounds progressed?

19 A. No.

20 Q. So you thought Hancock was obligated
21 under all circumstances to pay 200 million, is that
22 right?

23 A. Yes.

24 Q. Did you have an understanding as to what

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1 compounds were included in the basket?

2 A. I actually don't remember if I reviewed

3 the specific compounds.

4 Q. For example, did you know that ABT 773

5 was one of the compounds?

6 A. I actually don't remember if I reviewed

7 the compounds, so I don't remember what my

8 understanding was at the time. You have to

9 remember this was, what, seven years ago, and

10 actually only a few months after I had joined

11 Abbott, so I was still very much learning my way

12 around the Abbott pipeline and the Abbott R&D

13 portfolio.

14 Q. This was a significant deal for Abbott,

15 though, was it not, \$200 million in financing?

16 A. I am not sure -- sorry.

17 Q. Let me finish my question, please.

18 Obtaining \$200 million in financing from John

19 Hancock for pharmaceutical development, that was a

20 significant deal for Abbott, was it not?

21 A. I am not sure what you mean by

22 "significant."

23 Q. That has no meaning for you?

24 A. Well, it is not the meaning for me.

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1 would provide up to \$200 million to fund a basket
2 of Abbott pipeline assets in return for royalty
3 agreement. And because at the time Abbott had more
4 assets, if you will -- more pipeline assets than we
5 could afford to develop with our own money, this
6 was seen as a good thing to do for the business.

7 Q. Were you in favor of Abbott entering
8 into this agreement with Hancock?

9 A. Yes.

10 Q. Why did you think it was a good thing
11 for Abbott to do?

12 A. Because our job was to develop the best
13 medicines we could for our patients and that was
14 obviously good for our business, as well, and this
15 deal would allow us to develop or potentially
16 develop more of those assets.

17 Q. Would you turn to Page 24 of the
18 research funding agreement?

19 A. Okay.

20 Q. You see beginning at the bottom of
21 Page 24 onto the next few pages there are some
22 representations and warranties that Abbott made to
23 Abbott -- to John Hancock in this agreement, do you
24 see that?

1 A. Yes.

2 Q. Do you recall having any discussions

3 with anyone within Abbott about those

4 representations and warranties?

5 A. No.

6 Q. Were you aware at the time you signed

7 this agreement on Abbott's behalf that Abbott was

8 making representations and warranties to John

9 Hancock?

10 A. No.

11 Q. Have you executed other funding deals on

12 Abbott's behalf at any point in time?

13 A. When you say "funding deals," I am not

14 sure what you mean.

15 Q. Have you executed other contracts on

16 Abbott's behalf at various points in time?

17 A. Yes.

18 Q. Did any of those contracts contain

19 representations and warranties?

20 A. Did they? Is that what you are asking

21 me?

22 Q. Yes.

23 A. Yes.

24 Q. And you understood at the time that you

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1 were entering into this agreement with John Hancock
2 that John Hancock may rely on the terms of the
3 agreement, correct?

4 MR. WEINBERGER: Objection.

5 BY THE WITNESS:

6 A. Are you asking me did I understand that
7 at the time?

8 BY MR. DAVIS:

9 Q. Yes.

10 A. I don't remember what the terms of the
11 agreement were, so if you are asking me as, in
12 general, when you sign a contract do both parties
13 rely on the terms, the answer is yes. But in this
14 specific case, as I said, I don't remember the
15 terms of the agreement.

16 Q. Certainly, when you signed this contract
17 on Abbott's behalf, you understood that you were
18 binding Abbott to the terms of the agreement,
19 correct?

20 A. Yes.

21 Q. And you thought it would have been fair
22 for Hancock -- you understood that Hancock was
23 binding itself to the terms of the agreement as
24 well, correct?

1 A. When they signed it, yes.

2 Q. Did you ever meet Steven Blewitt?

3 A. No.

4 Q. Did you ever talk to Steven Blewitt?

5 A. No.

6 Q. And when Abbott entered into this

7 agreement with John Hancock, did -- to your

8 knowledge, was it Abbott's expectation that Hancock

9 would have to live by the terms of the agreement?

10 A. You say "Abbott's expectations," I am

11 not sure. Abbott isn't a person so --

12 Q. Was it your expectation when you signed

13 this agreement on Abbott's behalf that you expected

14 Hancock to live up to the terms of this agreement?

15 A. Yes.

16 Q. Would you think it was fair at that

17 point in time for Hancock to expect Abbott to live

18 up to the terms of the agreement?

19 MR. WEINBERGER: Objection.

20 BY THE WITNESS:

21 A. You say "fair." I expected Abbott to

22 live up to the terms of the agreement.

23 BY MR. DAVIS:

24 Q. Did you have any discussions with anyone

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1 Q. You don't recall seeing these slides

2 before?

3 A. No.

4 Q. The first slide, the one that is

5 numbered No. 1 at the bottom, the last bullet point

6 is "Permission to proceed to definitive agreement."

7 Whose permission was necessary within

8 Abbott in order to proceed to a definitive

9 agreement with John Hancock?

10 MR. WEINBERGER: At what point in time?

11 BY MR. DAVIS:

12 Q. Before the agreement was signed.

13 A. Based upon the fact of the signature

14 pages in the agreement, my permission was certainly

15 required. I don't remember whether Arthur Higgins'

16 permission was also required.

17 Q. Mr. Higgins reported to you at that

18 point in time?

19 A. When?

20 Q. March of 2001.

21 A. Yes.

22 Q. Did you need permission from anyone

23 above you in the Abbott organization in order to

24 enter into the research funding agreement with John

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1 Hancock?

2 A. I don't remember that. Abbott has a
3 series of policies with respect to the size of
4 agreements that can be signed. And I don't
5 remember at that time what they said, but based
6 upon the fact that I signed the agreement, I assume
7 that I had the authority to do that.

8 Q. Without further permission --

9 A. Without further permission, yes.

10 Q. Are you the person who made that
11 decision to enter into the agreement with John

12 Hancock?

13 A. I am the person who signed agreement.

14 Q. Are you the person who decided that
15 Abbott should enter into that agreement on Abbott's
16 behalf?

17 MR. WEINBERGER: Objection.

18 BY THE WITNESS:

19 A. Actually a whole series of people
20 decided that, but I assigned the agreement.

21 BY MR. DAVIS:

22 Q. Did you anyone above you in the Abbott
23 organization participate in that decision to enter
24 into the agreement?

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1 A. Not my recollection.

2 Q. So the buck stopped with you with

3 respect to the decision to enter into that

4 agreement with John Hancock, is that fair to say?

5 A. I take responsibility for signing the

6 agreement.

7 Q. And for making the agreement with Abbott

8 to enter into the agreement?

9 A. No, the decision was made by a group of

10 people who had various responsibilities in

11 evaluating that agreement.

12 Q. Ultimately, those people reported to

13 you, right?

14 A. Yes.

15 Q. And you were responsible, ultimately,

16 for making the decision based upon the

17 recommendations of people who worked for you that

18 Abbott should enter into the agreement, right?

19 MR. WEINBERGER: Objection, asked and

20 answered.

21 BY THE WITNESS:

22 A. I was responsible for signing the

23 agreement. The decision was made by a group of

24 experts who had helped me evaluate the agreement.

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1 BY MR. DAVIS:

2 Q. Who among the group of experts had the
3 final say in deciding whether Abbott would enter
4 into this agreement with John Hancock?

5 A. What do you mean by "the final say"?

6 Q. Making the final decision to go ahead
7 with the deal.

8 A. What do you mean by "the final
9 decision"?

10 The final decision was made by a group
11 of senior leaders at Abbott. I signed the
12 agreement.

13 Q. You were the senior member of that
14 group?

15 MR. WEINBERGER: Objection, asked and
16 answered.

17 BY THE WITNESS:

18 A. Yes.

19 BY MR. DAVIS:

20 Q. Did anyone in that group have the
21 ability to veto your decision? If you wanted to
22 enter into the agreement, did any of them have the
23 ability to veto your decision?

24 A. That's a much more complicated question

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1 because it gets to the way that we make decisions
2 and, certainly, the way we made decisions in my
3 organization.

4 So the way that we made decisions,
5 typically, about issues like this was a group of
6 experts evaluated the possibilities; evaluated, in
7 this case, the agreement and we discussed them and
8 came to consensus about whether it was a good thing
9 to do or not.

10 Q. Who were the group of experts?

11 A. In this particular case, the ones I
12 remember, as I said to you, were Arthur Higgins,
13 Jim Tyree and John Leonard. There were certainly
14 other people I am sure working with them and for
15 them that were involved in evaluating this and
16 helping to make the decision. And I am certain
17 there were lawyers involved in drafting the terms
18 of the contract.

19 Q. What else do you recall of your
20 discussions with Mr. Higgins, Mr. Tyree and
21 Mr. Leonard about the agreement or proposed
22 agreement with John Hancock before the agreement
23 was signed?

24 A. That's exactly what I already told you.

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1 ones refreshed your recollection, that's your

2 testimony?

3 A. My testimony is I was shown many

4 documents and I can't tell you specific ones, but I

5 am very happy if you show me a document to tell you

6 whether I saw it and whether it refreshed my

7 recollection. And any other documents you show me

8 today, I am happy to give you an answer on.

9 Q. For example, did you review the research

10 funding agreement yesterday?

11 A. No.

12 Q. Have you ever read that document?

13 A. I don't recall reading it.

14 Q. Was there -- did you assign primary

15 responsibility to someone under you in the Abbott

16 organization to oversee the negotiation of the

17 agreement with John Hancock?

18 MR. WEINBERGER: Objection.

19 BY THE WITNESS:

20 A. Again, let's go back to the history.

21 This negotiation had been going on before I ever

22 arrived at Abbott. It had been led by the three

23 folks that I told you about, Arthur Higgins, Jim

24 Tyree and John Leonard.

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1 Once I arrived at Abbott, they continued
2 to negotiate that and they had the responsibility
3 for negotiating it. I was not involved in the
4 direct negotiations at any time.

5 Q. My question is a little bit different.
6 So you took over responsibility for this portion of
7 Abbott in September of 2000, correct?

8 A. Which portion are we talking about?

9 Q. The position you assumed in September
10 2000 was as executive vice president, correct?

11 A. Yes, executive vice president of the
12 pharmaceutical products group.

13 Q. And this agreement with John Hancock was
14 being negotiated by people working within the
15 pharmaceutical products group, correct?

16 A. Yes.

17 Q. And so the time that you took over in
18 September of 2000, did you instruct any of the
19 people who were working for you within the
20 pharmaceutical products group that they were to
21 have primary responsibility for overseeing the
22 negotiations that were ongoing with John Hancock?

23 A. No. Did I instruct them? The answer is
24 no. But did some of them have primary

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1 responsibility which is continuing from the time
2 before I took over? Yes.

3 Q. Who among the people that you have
4 identified had primary responsibility for
5 negotiating the agreement with John Hancock?

6 A. It was a team effort as far as I
7 remember and that was Arthur Higgins, Jim Tyree
8 and, I believe, Dr. Leonard.

9 Q. Did they keep you informed of the
10 progress of the negotiations while they were
11 underway?

12 A. The only thing that I remember is to the
13 extent that they reviewed the terms of the
14 agreement with me, and the answer is yes.

15 Q. Did they review the terms of the
16 agreement with you over the course of the
17 negotiations?

18 A. Again, I just don't remember the precise
19 sequence of events and meetings. I know they
20 reviewed the terms of the agreement with me.
21 I know they did that before I signed the agreement,
22 but I don't remember the number of meetings or
23 exactly how they did it during the course of
24 events.

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1 Q. Who within your area of responsibility
2 did you designate as having primary responsibility
3 for overseeing, ensuring that the agreement was
4 complied with by Abbott after it was signed?

5 A. Yeah, my memory of this is there were
6 two groups involved. There was what subsequently
7 became the business development group, which was
8 directed by Jim Tyree, who then subsequently
9 reported to me.

10 And there was what subsequently became
11 what was called GPRD, global pharmaceutical
12 research and development, and within that group
13 Dr. Leonard was responsible for keeping track of
14 implementing, as you call it, this agreement.

15 Q. Did Dr. Leonard assist in any way in
16 reviewing the agreement before it was executed?

17 A. I believe he did, but, again, I was
18 fairly far from that. My memory of this was that
19 Arthur Higgins, Dr. Leonard and Jim Tyree had
20 primary responsibility for negotiating and
21 reviewing the agreement.

22 Q. What steps did you take before the
23 agreement was signed to ensure that any information
24 provided by Abbott to Hancock in the agreement was

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1 truthful and accurate?

2 A. The same steps that we always took,
3 which was to make sure that there were experts in
4 those areas that were covered in the agreement who
5 were negotiating and reviewing the agreement, and
6 they included lawyers. In this case, as I said,
7 Dr. John Leonard, Arthur Higgins and Jim Tyree, who
8 each had had expertise in a different area that was
9 relevant to the agreement.

10 Q. What was the area of expertise that
11 Dr. Leonard had?

12 A. He had expertise regarding the
13 scientific and medical evaluation of the compounds
14 in the development programs.

15 Q. So is it fair to say that Dr. Leonard
16 was the one who was responsible before the
17 agreement was signed with ensuring the accuracy of
18 any technical or scientific information regarding
19 the compounds?

20 A. He was one of the people, and there may
21 have been people working for him who helped him
22 with that, but he was the most senior person.

23 Q. Is he the person that you counted on as
24 of March 2001 to ensure that any scientific or

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1 technical information contained in the agreement

2 was truthful and accurate?

3 MR. WEINBERGER: Objection.

4 BY THE WITNESS:

5 A. Yes.

6 BY MR. DAVIS:

7 Q. What discussions did you have with
8 Dr. Leonard in that time frame to confirm that he
9 was doing his job?

10 A. Again, I can't tell you about specific
11 meetings, but we had -- "we" meaning Mr. Higgins,
12 Dr. Leonard and Jim Tyree -- had conversations
13 about what was included in the agreement.

14 Q. What was --

15 A. The terms of the agreement, in other
16 words.

17 Q. What was the substance of those
18 conversations, if you haven't already provided it
19 to me?

20 A. I think I have. In other words, that
21 the agreement provided for up to \$200 million of
22 funding, I believe it was up to \$50 million a year
23 for four years, to fund the development of a basket
24 of compounds in return for a royalty arrangement

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1 A. Yes.

2 Q. Have you seen any of these compound
3 reports before that follow Page 51?

4 A. Let me look. I saw some of these as
5 documents we reviewed yesterday with counsel. I
6 had not remembered seeing them before then.

7 Q. You recall at the time Abbott entered
8 into the research funding agreement with Hancock
9 that Abbott provided information about the various
10 compounds that were in that basket to John Hancock?

11 A. I didn't until I saw the documents
12 yesterday.

13 Q. Was it Dr. Leonard's responsibility,
14 if -- these compound reports contain information,
15 scientific and technical information about the
16 compounds, you see that?

17 A. Yes, I see that.

18 Q. Was it Dr. Leonard's responsibility for
19 ensuring that the technical and scientific
20 information about the compounds contained in these
21 reports was truthful and accurate as of the time
22 the agreement was signed?

23 A. It was Dr. Leonard and his team.

24 Q. But his team who reported to

1 Dr. Leonard?

2 A. Yes.

3 Q. Again, ultimately, Dr. Leonard's

4 responsibility, correct?

5 A. Actually, can I qualify my answer to

6 that? When you say "his team that reported to

7 Dr. Leonard," there were scientists in the R&D

8 organization, for instance, discovery scientists,

9 who could have provided some of these facts that

10 did not report directly to Dr. Leonard. They

11 reported to Dr. Norbeck.

12 Q. Ultimately, you regard Dr. Leonard as

13 being the head of that team, correct?

14 A. Yes.

15 Q. And the one primarily responsibility for

16 getting that job done, correct?

17 A. Yes.

18 Q. And as you sit here today, do you have

19 any recollection of any discussions with

20 Dr. Leonard on the steps that he took before this

21 agreement was signed to ensure that the information

22 being provided to John Hancock, the scientific and

23 technical information about the compounds, was

24 accurate?

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1 A. No, I never had such discussions with
2 him.

3 Q. You never had such discussions or --

4 A. I don't recall any such discussions with
5 Dr. Leonard.

6 Q. Would you look at back at Exhibit 2, the
7 same page that Bates ends with 754?

8 A. Which page again.

9 Q. 754, the matrix that we were looking at
10 a moment ago.

11 A. Yes.

12 Q. To the right of the box labeled
13 Portfolio, there is another box labeled Financials,
14 do you see that?

15 A. Yes.

16 Q. It says, "Expected Portfolio
17 Requirements 800 through 804," do you see that?

18 A. Yes.

19 Q. What are expected portfolio
20 requirements?

21 A. Again, I am speculating here because I
22 didn't prepare the document.

23 MR. WEINBERGER: I don't think Mr. Davis wants
24 you to speculate, so if you have some knowledge you

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1 know the return that they calculated. However,
2 using our expected sales, it is estimated that the
3 final terms of the deal generated an expected IRR
4 of 22 to 25 percent." Do you see that?

5 A. Yes.

6 Q. That's an IRR for Hancock, correct?

7 A. That's my interpretation of this, yes.

8 Q. Then the bottom bullet point says, "In
9 summary, over the last two years, Hancock has seen
10 the portfolio reduced from nine compounds down to
11 three active, and the estimated expected IRR
12 reduced from about 23 to 17 percent." Do you see
13 that?

14 A. Yes.

15 Q. Again, that's Hancock's IRR?

16 A. That's my understanding of this, yes.

17 Q. Did Abbott ever calculate an internal
18 rate of return on this particular deal?

19 MR. WEINBERGER: You mean for Abbott?

20 BY MR. DAVIS:

21 Q. For Abbott.

22 A. I am not aware if they did.

23 MR. DAVIS: Let's mark this please as the next
24 exhibit.

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1 (WHEREUPON, said document was marked
2 Leiden Deposition Exhibit No. 5, for
3 identification, as of 4/26/07.)
4 BY MR. DAVIS:
5 Q. Dr. Leiden, you have what's been marked
6 as Exhibit 5. I think it is a three-page document
7 that refers to a portfolio review meeting on
8 March 7, 2001 at the Hyatt in Deerfield. Do you
9 see that?
10 A. Yes.
11 Q. And your name is at the top under
12 Welcome/Introduction, "J. Leiden." Do you see
13 that?
14 A. Yes.
15 Q. Did you attend this portfolio review
16 meeting?
17 A. Yes.
18 Q. What is a portfolio review meeting?
19 A. Do you want to know generally or do you
20 know want to know about this one?
21 Q. Let's talk generally, first.
22 A. Generally, a portfolio review meeting is
23 one where we could review a portfolio of R&D
24 products, or we could review a portfolio of

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1 commercial products, or we could review a
2 particular therapeutic area going forward. So
3 there were multiple forms of such a meeting
4 generally.

5 Q. In this particular portfolio review
6 meeting, what was the purpose of this meeting?

7 A. This was a very special portfolio review
8 meeting. That's the reason I remember it from
9 seven years ago. We had an acquired the Knoll
10 division of BSF, which was the pharmaceutical
11 division of BSF, at the very end of 2000, early
12 2001. The deal, I believe, closed some point in
13 April of 2001.

14 And as part of that acquisition, we
15 acquired a new set of R&D compounds or projects.
16 And we also acquired, if you will, an increase in
17 R&D funding. So Knoll had their own R&D funding.
18 We had R&D funding. We put those two together. We
19 had a set of compounds. Knoll had a set of
20 compounds. We put those two together.

21 After having done that, we still had
22 many more compounds in our R&D portfolio than we
23 could afford to fund with the combined funding from
24 Knoll and Abbott, so it was a perfect time to now

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1 to put all of these compounds and projects together
2 into one portfolio, if you will, and review them in
3 terms of chance of success, both technical success
4 and commercial viability, and then assign the R&D
5 funding to the new set of projects.

6 So it was a way of reviewing the entire
7 new R&D portfolio, the entire new R&D budget, and
8 then deciding which compounds were the best ones
9 that would be funded.

10 Q. So it is fair to say this particular
11 portfolio review meeting that's discussed in
12 Exhibit 5 was prompted in large part by the Knoll
13 acquisition, is that right?

14 A. Yes, entirely.

15 Q. And the purpose behind the portfolio
16 review was to get, as I think you have stated, to
17 take, sort of, all the compounds that now existed,
18 including those that came over from Knoll, and to
19 review them all together in order to make decisions
20 about which ones Abbott would continue to pursue
21 given the availability funding, is that right?

22 A. It wasn't which ones Abbott would
23 continue to pursue. It was a little more specific
24 than that. It was essentially ranking them by

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1 priority. And the priority was based both upon
2 technical feasibility and commercial return,
3 commercial feasibility, and medical need. And once
4 they were prioritized, then assigning the existing
5 R&D budget to fund down that list.

6 The reason I am giving you this
7 clarification is it doesn't mean that things that
8 we decided not to fund here at this portfolio
9 review never got funded. They might be put on
10 hold. They might have been funded later. They
11 might have been funded as part of the partnership.
12 So it was really to prioritize the R&D compounds
13 and assign the existing funding to those compounds
14 for the rest of this year.

15 Q. So the purpose of the meeting was to
16 try, as you say, to prioritize the various
17 compounds and to determine which ones Abbott would
18 continue to pursue at that point in time given the
19 available funding?

20 MR. WEINBERGER: Objection.

21 BY THE WITNESS:

22 A. Again, I want to -- I am not trying to
23 raise too many subtleties, but I want to be very
24 clear in my answer to you.

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1 part of the Hancock deal?

2 A. I believe so, but I had no direct
3 involvement in that because, again, I had delegated
4 the management of that to Dr. Leonard as head of
5 development and Mr. Tyree as head of business
6 development group.

7 Q. Would you look again at Exhibit 5 for a
8 moment, please. There were recommendations made in
9 the course of the portfolio review meeting that's
10 referenced in Exhibit 5?

11 A. Not in the course of the meeting. My
12 memory of this was that everybody presented their
13 programs in short presentations. And again, a
14 group -- I don't know if we called it the PEC at
15 that time, but a group of commercial, R&D,
16 manufacturing leaders, as well as myself, met at
17 the end of that meeting to try to prioritize these
18 programs.

19 Q. Who were the other members of that group
20 that participated in the prioritization that
21 resulted from this March 7 to 9th, 2001 portfolio
22 review meeting?

23 A. I will tell you as best as I can recall,
24 because it was a long time ago. Dr. Leonard was a

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1 member of that group. Arthur Higgins was a member
2 of that group. Bill Dempsey was a member of that
3 group. Dan Norbeck was a member of that group.
4 Xavier Rapez was running the Knoll integration from
5 an R&D standpoint and he was a member of that
6 group. John Langraph, who ran manufacturing, was a
7 member of that group. I believe Eugene Sun was a
8 member of that group. Chris Ward, who ran
9 regulatory, I believe, was a member of that group.
10 There were some McKenzie consultants who were
11 helping out with the integration of Knoll, who --

12 Q. You had McKenzie consultants attend this
13 portfolio review meeting?

14 A. There may have been folks there taking
15 notes, because part of their responsibility was to
16 take notes, or some of them may have been taking
17 notes. I don't remember if they were there or not.

18 There was, I think, a guy named Bob
19 Cayman, who was a -- he came from Knoll. He
20 subsequently ran our Abbott bioresearch efforts,
21 which was a monocloning antibody facility we had
22 acquired from Knoll in Wooster, Mass. I believe he
23 was there. Those are the folks I can remember.
24 There could have been more.

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1 was designed to do. That's why it was important.

2 Q. That's why it was critical?

3 A. That's why it was important. That's

4 what you asked me, I think.

5 Q. A moment ago you referred to the trial

6 as critical. If there is a difference between

7 important and critical, please explain it to me

8 now.

9 A. Let me clarify what I meant. The data

10 that came out of this trial was important for us to

11 decide the scientific and commercial viability of

12 594.

13 MR. DAVIS: Let's mark this as the next

14 exhibit, please.

15 (WHEREUPON, said document was marked

16 Leiden Deposition Exhibit No. 10,

17 for identification, as of 4/26/07.)

18 BY MR. DAVIS:

19 Q. Dr. Leiden, you have what's been marked

20 as Exhibit 10, which appears to be a presentation

21 titled "Pharmaceuticals Strategy Updates,

22 September 2000."

23 Again, this is represented to us by your

24 counsel came from your files.

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1 Have you seen this presentation before?

2 A. So I don't remember this precise

3 presentation, but I certainly prepared a number --

4 I recognize a number of the slides in this

5 presentation. It is the format that I would

6 typically use in a presentation, and I certainly

7 prepared some of these slides, so I do remember

8 that.

9 Q. Were you working on a pharmaceutical

10 strategy as of September 2000?

11 A. Yes, with my team.

12 Q. Is this presentation pertaining to that

13 strategy you were working on?

14 A. Yes.

15 MR. DAVIS: I am going to mark as the next

16 exhibit what I think is a copy of the same document

17 in color.

18 (WHEREUPON, said document was marked

19 Leiden Deposition Exhibit No. 11,

20 for identification, as of 4/26/07.)

21 BY MR. DAVIS:

22 Q. Now, Dr. Leiden what I would like to do

23 is focus your attention on -- you have Exhibit 10

24 there, as well, which is the black and white copy.

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1 If you turn to the page of Exhibit 10 that's Bates
2 number ends in 5504, please.

3 A. Yes.

4 Q. And then if you turn to the page of
5 Exhibit 11, that is labeled -- ends in 7846. Do
6 you see that?

7 A. Yes.

8 Q. Just compare those for a moment. These
9 appear to be -- again, we asked for a color copy of
10 Exhibit 10, and we were provided with what has been
11 marked as Exhibit 11. And these pages at least
12 seem to be the same.

13 Can you just look at them for a moment
14 and see if you see any differences other than one
15 is in black and white and the other is in color?

16 MR. WEINBERGER: Why don't we just use the
17 color one. I am not sure what the point of this
18 is.

19 BY THE WITNESS:

20 Q. You are testing my eyesight here on a
21 little one.

22 BY MR. DAVIS:

23 Q. Believe me, it tested ours, as well.
24 That's why we asked for a different copy.

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1 A. Again, with the caveats that I can't
2 read some of the print on the little one and there
3 is certainly no colors on the little one that I can
4 discern, they look to be similar or identical.

5 Q. Now, the slide is titled "The imbalance
6 in the Abbott pipeline."

7 What was it intended to convey, what
8 information?

9 A. It was intended to convey the notion
10 that we had a relatively large number of late stage
11 projects, such as the ones listed, ABT-378 and
12 ABT-773, in that column you see there.

13 And we had a relatively large number of
14 early stage products, that's represented by the
15 left column for instance, starts with ABT-828. Do
16 you see that?

17 But in the middle of the pipeline, there
18 were -- meaning in the two columns that start with
19 Abbott-963 and ABT-594 -- Do you see those two
20 columns?

21 Q. Yes.

22 A. Those two, there are relatively few
23 compounds there, so it had sort of a dumbbell
24 shape; lots of very early compounds, reasonably

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1 large number of late compounds, and a relatively
2 small number of compounds in the middle of the
3 pipeline.

4 Q. Did you see this document yesterday?

5 A. I saw this slide yesterday, but I can't
6 tell you because I haven't looked through the whole
7 document that it was this document.

8 Q. One of the compounds referenced here
9 under Phase II is ABT-594. Do you see that?

10 A. Yes.

11 Q. You have got it labeled here in red,
12 which at the bottom equates to "questionable
13 commercial viability." Do you see that?

14 A. Yes.

15 Q. Why was it that you regarded ABT-594 as
16 having questionable commercial viability as of
17 September 2000?

18 MR. WEINBERGER: I don't quarrel with it, but
19 I don't think you have established whether or not
20 he prepared this slide, so.

21 MR. DAVIS: I think he testified earlier that
22 this had do with his strategy update.

23 MR. WEINBERGER: He said he prepared some of
24 the slides. You didn't ask him about this one,

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1 specifically. He may have. I just think there is
2 a hole in the record here.

3 BY MR. DAVIS:

4 Q. Dr. Leiden, these slides were prepared
5 by you or someone in your group, is that right?

6 A. Yes, by me or someone in the group.

7 Q. I take it that you understood the slides
8 to be reasonably accurate at the time they were
9 prepared?

10 A. Yes.

11 Q. Now, can you tell me why it was that as
12 of September 2000 you regarded ABT-594 as having
13 questionable commercial viable?

14 A. Sure. So in Phase II, the way that I
15 remember we distinguished these compounds was those
16 that had a statistically significant Phase II
17 result, we considered -- for instance, in this
18 case, ABT-627, which had had a statistically
19 significant Phase II trial, a trial already behind
20 it, we considered it as commercially viable. And
21 those that had not yet had that data, we considered
22 Phase II as commercially questionable. Not not
23 viable, but questionable.

24 Q. To your knowledge, was John Hancock ever

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1 told before the research funding agreement was
2 signed that Abbott regarded ABT-594 as having
3 questionable commercial viability?

4 A. I don't know whether they were shown
5 this slide.

6 Q. On occasion, when you worked at Abbott,
7 did Abbott partner with other companies on the
8 development of pharmaceutical compounds?

9 A. Yes.

10 Q. On occasion did Abbott in-license
11 pharmaceutical compounds with other companies?

12 A. Yes.

13 Q. In doing so, did Abbott do some due
14 diligence about regarding those compounds in order
15 to determine, sort of, the status of the compound?

16 A. Yes, of course.

17 Q. And one of the things that you or Abbott
18 would want to know in its due diligence was how the
19 compound was regarded by its partner or potential
20 partner?

21 MR. WEINBERGER: Object to the form of the
22 question.

23 BY THE WITNESS:

24 A. What we would really want to know is the

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1 data that were available in that compound, because
2 typically in due diligence, it was much more
3 important to make our own decisions about the
4 quality of that data than, frankly, what the other
5 company thought about it.

6 So our due diligence typically involved
7 a complete review of the data and we would make our
8 own assessment as to what was -- both the
9 scientific and the commercial viability.

10 BY MR. DAVIS:

11 Q. Would you want to know if your partner
12 or potential partner regarded that compound,
13 particular compound, as having questionable
14 commercial viability?

15 A. Again, I want to define what we meant
16 here. So we meant by "questionable commercial
17 viability," that there wasn't a statistically
18 significant Phase II trial out there and we would,
19 of course, want to know that, but it would be easy
20 to know that because we would look at the data.

21 For instance, in this case, my
22 understanding is that John Hancock had a copy of
23 the data, knew exactly which trials were done and
24 which trials weren't done, and so they knew this

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1 already because our definition of this was what had
2 a Phase II result.

3 And my understanding, at least from what
4 I saw yesterday in the documents, was that John
5 Hancock knew which results were there and which
6 results were pending.

7 Q. Was a copy of this slide presentation
8 made available, Leiden --

9 A. I don't know that.

10 Q. -- Exhibit 11?

11 A. I don't know that.

12 Q. If you learned in the course of due
13 diligence of a compound that your partner or
14 potential partner regarded it as having
15 questionable commercial viability, would you want
16 to dig into that and learn the reasons for that?

17 MR. WEINBERGER: Object to the form of the
18 question.

19 BY THE WITNESS:

20 A. We would want to know exactly what data
21 was out there with respect to Phase II before we
22 licensed a Phase II compound, and we would always
23 have that information available from the other
24 company, just as we had made it available to

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1 think about the commercial viability of drugs to
2 explain how it was defined and what the difference
3 between those two is.

4 Q. Let me just -- I will take you through
5 it. Thank you. We have a various categories here.

6 One is "significant commercial
7 potential." That was a good thing, correct?

8 MR. WEINBERGER: Object to the form of the
9 question.

10 BY MR. DAVIS:

11 Q. When drugs that were identified on this
12 slide as having significant commercial potential,
13 you regarded that as a very favorable thing,
14 correct?

15 A. "Significant commercial potential" means
16 that there was data, scientific data, available to
17 support the fact that the drug would, A, likely
18 make it all the way through the pipeline and have
19 properties or characteristics that would allow it
20 to be marketed successfully, but there was data
21 available to say that.

22 Q. Which you regarded as a good thing?

23 A. Those are a good thing.

24 Q. Abbott's in this business to make money,

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1 correct?

2 A. Abbott's in the business for two

3 reasons, to provide the best drugs to take care of

4 patients and, in doing so, to make money.

5 Q. And putting together this slide, one of

6 the things that you were trying to convey to people

7 who saw this slide was, sort of, the relative

8 prospects for the various compounds that are listed

9 here, correct?

10 A. I was trying to convey what we knew and

11 what we didn't know and so how, what we felt the --

12 I was trying to convey our current state of

13 knowledge about these compounds.

14 Q. Including the commercial prospects for

15 the compounds, right?

16 A. Yes, including the commercial prospects.

17 Q. When you have here in the blue,

18 "significant commercial potential," that was very

19 favorable? That was a good thing for a compound to

20 have significant commercial potential?

21 MR. WEINBERGER: It's been asked and answered,

22 objection.

23 BY THE WITNESS:

24 A. It meant that there was scientific data

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1 out there that suggested that the product had a
2 profile that would allow approval and successful
3 commercial launch; that we knew that already.

4 BY MR. DAVIS:

5 Q. When you have in blue here, "significant
6 commercial potential," that meant that the compound
7 had greater commercial potential than a compound
8 that was listed in gold, correct?

9 A. No, it meant that we knew it had greater
10 commercial potential.

11 Q. It says "greater than \$500 million,"
12 correct?

13 A. We had enough data to make that
14 assessment. That's what it meant.

15 Q. Then commercially successful were
16 compounds that fell within the range of 250 to
17 500 million, correct?

18 A. We had enough data to conclude that
19 that's likely where those compounds were going to
20 end up.

21 Q. And 250 to 500 million, is that annual
22 sales?

23 A. Yes.

24 Q. Annual peak sales?

1 A. Yes.

2 Q. And then commercially viable, that was
3 another category that had likely peak sales in the
4 range of 100 to 250 million, correct?

5 A. Correct. The reason I am laughing is
6 because if you look at the commercially viable, the
7 green ones that you just asked me about, which we
8 said had 100 to 250, and you go down the list,
9 Flomax sold over a billion, Omnicef 700 million,
10 Micardis over a billion, Norvir probably 400
11 million, et cetera. Mobic over a billion. So I
12 was just laughing because, obviously, our ability
13 to predict that was actually somewhat limited, but
14 anyway that's a separate question.

15 Q. Then when you have listed uncertain
16 commercial viability, that means you really had
17 difficulty determining at that point in time what
18 the likely viability -- commercial viability of
19 that compound was, correct?

20 A. Well, what you see here is that all of
21 the uncertain commercial viability is the black
22 compounds, they were all in Phase I or earlier, and
23 so what it really reflects is at that point in a
24 drug's development there is simply never enough

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1 data to really make any assessment at all.

2 Q. So what I said is correct in that by
3 marking them as having uncertain commercial
4 viability, what you are really saying is that you
5 didn't have enough information at that point in
6 time, perhaps because they were early stage, to
7 give a good indication of the likely commercial
8 viability of a compound, is that right?

9 A. No, that's not what I said.

10 MR. WEINBERGER: You added those words.

11 MR. DAVIS: Please no commentary.

12 BY THE WITNESS:

13 A. I want to be very clear about it. The
14 reason those compounds which are all on the left
15 side of the slide were shown as uncommercial
16 commercial viability is they were too early to know
17 anything about them. That's the distinction.

18 BY MR. DAVIS:

19 Q. The ones that are listed as questionable
20 commercial viability in the red, are the ones in
21 which you have information to make some assessment
22 of the likely commercial viability, but the
23 commercial viability of those compounds is less
24 favorable -- the likely commercial viability of

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1 those compounds is less favorable than the ones we
2 see in blue, gold, or green, correct?

3 A. No. So you and I are making separate
4 distinctions, and I will keep making it to you just
5 until you understand. I am not saying this very
6 well perhaps.

7 The difference between these compounds
8 has to do with the amount of information that we
9 have to make the assessment. By the way, that
10 assumes that we are good at making the assessment.
11 That's why I was laughing, because as I look at
12 now, we obviously weren't very good at it.

13 In any event, at that time to the best
14 of our knowledge the question was really "Do we
15 have enough information to positively make the
16 assessment of both the scientific and therefore the
17 commercial viabilities of these compounds?" And we
18 are trying to divide them into different categories
19 based upon the amount of information that we have
20 and how well we can assign their eventual
21 commercial use.

22 So for the compounds in black, we don't
23 have, essentially, any information and so we can't
24 say anything. For the compounds in blue, as an

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1 example, we felt that we had enough information to
2 actually have a fairly high degree of certainty
3 that they had commercial potential of greater than
4 500 million because we had scientific data that we
5 thought told us that.

6 And for the compounds in red, we didn't
7 have enough scientific information -- even though
8 they were later, we did not yet have enough
9 scientific information to actually assign where
10 they were going to lie in that commercial
11 viability.

12 Again, I would just go back and say to
13 you, because it is sort of interesting, if you look
14 at how we assign these, frankly, we weren't right
15 much of the time in both directions.

16 In the compounds in green, actually
17 almost every one of them -- I believe every one
18 except Gabitril had a significantly greater
19 commercial viability. In the compounds in blue,
20 for instance, ABT-627, that we had thought had
21 significant commercial potential, so far that has
22 not made it to market and sold anything.

23 Q. Is it still under development?

24 A. I don't know that. When I left Abbott

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1 it was, but I don't know where it is now because I
2 don't have any information. And, you know, in some
3 of the other compounds, like Co-actinon and
4 Co-viracil, which were partner -- they came from a
5 partner, who then subsequently developed them, I
6 believe both of them did make it to the market and
7 did quite well.

8 So my only point being we tried to
9 assign that based on the knowledge we had, and,
10 obviously, in retrospect, that knowledge was quite
11 imperfect.

12 Q. ABT-594 was discontinued ultimately?

13 A. Yes.

14 Q. How about ABT-822?

15 A. Yes.

16 Q. How about ABT-890 -- sorry, 980?

17 A. Yes.

18 Q. How about Uprima?

19 A. I think Uprima was -- Uprima was
20 launched actually in Europe.

21 Q. Under what name?

22 A. Uprima in Europe, yes.

23 Q. In Europe only?

24 A. I believe in Europe only, again, by the

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1 time I left Abbott.

2 Q. In Europe only, I am sorry, correct?

3 A. Yes.

4 Q. When was that?

5 A. I am sorry, I don't remember. It was

6 somewhere between 2003 and 2005.

7 Q. And what were the trade names for

8 Co-actinon and Co-viracil?

9 A. I don't know what the eventual trade

10 names were. They were launched by, eventually,

11 I think by Triangle, who was bought by Gilead.

12 Q. So those were compounds that were in the

13 Abbott pipeline as of 2000, but ultimately were

14 introduced by other companies?

15 A. Correct. They were partnership and we

16 actually gave up or sold our rights to that

17 partnership or whatever.

18 Q. So those were not introduced by Abbott?

19 A. Correct.

20 Q. How about Uprima, was that introduced by

21 Abbott?

22 A. Yes.

23 Q. Out of the ones that are listed in red,

24 the only one that was actually introduced by Abbott

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1 is Uprima?

2 A. Yes.

3 MR. WEINBERGER: A couple things, one, by the
4 way, we are designating at least at this point the
5 transcript as confidential. Secondly, can we take
6 a break? It has been an hour and ten minutes.

7 MR. DAVIS: Can we can take a break. Can we
8 do a five-minute break?

9 MR. WEINBERGER: Yes, absolutely.

10 THE VIDEOGRAPHER: Going off the video record
11 at 10:58 a.m. This concludes Tape No. 2.

12 (WHEREUPON, a recess was had.)

13 THE VIDEOGRAPHER: We are going back on the
14 video record at 11:06 a.m. This is the beginning
15 of Tape No. 3.

16 BY MR. DAVIS:

17 Q. Dr. Leiden, the pharmaceutical strategy
18 update, to whom was that presentation made?

19 A. Presentations of this, I am not sure if
20 it is exactly this, but certainly quite close, many
21 of these slides were made to the board, I believe,
22 at what was our June board meeting that year.

23 And versions of this -- again, I can't
24 tell you it was exactly this one, but versions of

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1 this were made to a variety of management
2 leadership meetings and also I think a couple of
3 all employee meetings either by me, but in some
4 cases, I believe, by my division heads.

5 Q. When you say "the board," you mean
6 Abbott's board of directors?

7 A. Yes.

8 Q. And that would include Mr. White?

9 A. Yes, he is chairman of the board.

10 Q. Do you recall making this presentation,
11 this one particular, Exhibit No. 11?

12 A. Again, I don't know if it was this one,
13 but I recall making a similar presentation to the
14 board, as I said, with Arthur Higgins in June.
15 I just don't recall this one. I don't know who
16 this was made to.

17 Q. All right. There is on the second page
18 of Exhibit 11, at the bottom, it says, "This
19 strategy was first presented to the board at least
20 year's June meeting in London."

21 A. Right.

22 Q. That's a presentation you recall making
23 to the board at some point in time?

24 A. Yes, and I believe -- what was the date?

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1 Yeah, it was believe it was June, I think, last
2 year, I think it was June of 2000.

3 Q. Is this an update to the board
4 Exhibit 11?

5 A. I don't know what this was actually.
6 I just don't remember what this came from, but I
7 doubt it because I think there was just one
8 presentation made to the board and that was in
9 June of 2000.

10 MR. DAVIS: Would you mark this as please as
11 the next exhibit.

12 (WHEREUPON, said document was marked
13 Leiden Deposition Exhibit No. 12,
14 for identification, as of 4/26/07.)

15 BY MR. DAVIS:

16 Q. Dr. Leiden, Exhibit 12 is an e-mail with
17 an attachment, that the e-mail itself is from a
18 Michael Spengler to a variety of people titled
19 "Jeff Leiden Presentation." And then attached to
20 the, again, the e-mail is a color copy of a
21 PowerPoint presentation titled "Growing and
22 Enhancing World-Class Global Research and
23 Development at Abbott" with your name on the front
24 page. Did you make this presentation?

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1 federal rules. Every time you say that I am trying
2 to decide how we that's different from the federal
3 rules. That's why I hesitated.

4 MR. DAVIS: I just want to make sure we don't
5 have any agreement that anything has been altered.

6 (WHEREUPON, said document was marked
7 Leiden Deposition Exhibit No. 14,
8 for identification, as of 4/26/07.)

9 BY MR. DAVIS:

10 Q. You have in front of you Dr. Leiden
11 Exhibit No. 14, which is e-mail from a Mike
12 Williams to Jennifer Smoter and with a cc to
13 Dr. Chris Silber. Do you see that?

14 A. To Jennifer Smoter, cc Chris Silber,
15 yes.

16 Q. And it is dated October 12, 2000. The
17 e-mail itself states, "Jennifer, I think Mike
18 Decker has addressed some of the document issues.
19 Another real issue we must address, given some of
20 the internal discussions around the clinical trials
21 of ABT-594, is whether we want to make any
22 statements in the next few weeks until a decision
23 is made by Jeff Leiden as to whether we continue
24 the trials." Do you see that?

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1 A. That's what it says, yes.

2 Q. What decision were you considering as of
3 October 2000 concerning the fate of the clinical
4 trials for ABT-594?

5 A. I have no idea what this talks about.
6 First of all, I don't even know who Mike Williams
7 is, and I have no idea what this is referring to.

8 Q. You have no recollection of
9 participating in any internal discussions about the
10 clinical trials of ABT-594 in October or in or
11 around October 2000?

12 A. As I said to you, the only recollections
13 I have around the clinical trials -- that clinical
14 trial, we are talking now about that Phase IIb
15 clinical trial, is whether -- is looking at a
16 statistical analysis of the trial to ask whether it
17 would be possible to stop short of the 320 patients
18 and still have enough statistical power to get an
19 answer which would allow us to save money and time.
20 Those are the only discussions I remember.

21 Q. Who did you have those discussions with?

22 A. I think we had them on several occasions
23 at PEC meetings because my memory of this is that
24 asked the -- "we" meaning myself, John Leonard and

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1 the PEC, and Bruce McCarthy was probably involved
2 because I think he was project leader, asked the
3 statisticians to go back and redo the power
4 calculations based upon our projections for patient
5 enrollment to see at several levels what kind of
6 power we would retain for answering the question I
7 told you about in the earlier part of the trial
8 design.

9 Q. What do you recall as to the reason why
10 Abbott was having those discussions?

11 A. They were typically discussions we had
12 around almost any trial as it came to the end. For
13 instance, we had the same exact discussions around
14 ABT-627 because in this business time is money,
15 huge amounts of money. And so if we could make a
16 positive or negative decision two or three months
17 earlier, with fewer patients, we would actually
18 save ourselves a lot of time and money.

19 So my memory of this is as the trial --
20 as we got up above 250 or so patients, we then
21 asked the question which we always ask at these
22 trials, at 250, at 270, at 300, at 320, go back and
23 do a power calculation and tell us whether we lose
24 power or whether we still have approximately the

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1 same power. My memory of that is when we did that
2 calculation, once we got up to around 270 or
3 somewhere around that number of patients, that we
4 had virtually identical power to 320, which was the
5 reason that we eventually decided to stop the trial
6 after 270. It saved us time.

7 Q. So you do recall participating in a
8 decision to stop that trial before it reached its
9 target enrollment?

10 A. Yes.

11 Q. Who else was involved in that decision
12 making process?

13 A. So certainly John Leonard, Bruce
14 McCarthy, one of the statisticians or several of
15 the statisticians, I don't remember which ones, and
16 I believe the entire PEC. I think that was a
17 presentation that was made to the pharmaceutical
18 executive committee in its total, and we came to a
19 consensus that that was the right thing to do.
20 That's my memory of it.

21 Q. You said it was done in large part to
22 save money?

23 A. When I say "save money," I want to be
24 clear. The ability -- there are two ways that

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1 stopping trials early are very helpful. One is
2 that if you get a positive result, you now have
3 accelerated the development timeline. And
4 literally for drugs this size, every month in the
5 development timeline you save can be worth tens of
6 millions of dollars, so that's one way you can save
7 money.

8 The other way, of course, is if you stop
9 the trial early, you can usually save some,
10 although not huge amounts, but some amounts of
11 money because your trial costs go down. In other
12 words, every month there is a burn rate in the
13 trial. And so it is tremendously advantageous if
14 you have the right power and you are sure you have
15 the right power to stop trials early, and we have
16 done it with a couple of different drugs.

17 Q. Did ending that trial early have any
18 effect whatsoever on the statistic power of the
19 study?

20 A. Minimal. I don't remember the exact
21 numbers, but my memory was it was still above 85
22 percent, which is the power that we usually look
23 at.

24 Q. Were there --

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1 So it did have -- I am sure it played a role in the
2 power calculation, because the power calculation
3 was based upon the actual number of patients that
4 completed the study.

5 And so, I guess, the formal answer to
6 your question would be no, because the power
7 calculation was based, in part, upon the total
8 number of patients completed, which, of course,
9 reflected the dropout rate.

10 Q. Did the questionable commercial
11 viability of ABT-594 play any role in the decision
12 to end that trial early?

13 MR. WEINBERGER: Objection.

14 BY THE WITNESS:

15 A. You know, of course not. By ending the
16 trial, we got the answer that we were looking for,
17 the data that we were looking for, which allowed us
18 to make the decision.

19 BY MR. DAVIS:

20 Q. Did the fact that Abbott regarded
21 ABT-594 as having questionable commercial viability
22 in the fall of 2000, did that play any role in the
23 decision to end that Phase IIb clinical trial
24 early?

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1 A. As I told you, the definition on the
2 slide that you showed me of questionable commercial
3 viability was the lack of statistically significant
4 Phase II data, so this study was designed to give
5 us statistically significant Phase II data and
6 so -- which it did, and so the decision to end the
7 study early meant that we got that data quicker.

8 MR. DAVIS: Why don't we mark that as the next
9 exhibit.

10 (WHEREUPON, said document was marked
11 Leiden Deposition Exhibit No. 15,
12 for identification, as of 4/26/07.)

13 BY MR. DAVIS:

14 Q. Dr. Leiden, you have what's been marked
15 as Exhibit 15 at your deposition. It is a two-page
16 document entitled "PPD Plan Review, 10/16/00." Do
17 you see that?

18 A. Yes, I do.

19 Q. And it appears to be a reference to a
20 number of different projects on here, including
21 594. Do you see that near the bottom of the page?

22 A. Yeah, it says "980 and 954 savings,"
23 yes.

24 Q. Right underneath that it says "JML

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1 A. Yes.

2 Q. Were you aware in late 2000 that that
3 study was experiencing a 35 percent dropout rate?

4 A. I am sorry, I don't remember that.

5 Q. Do you recall any discussions within
6 Abbott about that being a concern?

7 A. Again, the only discussions I recall in
8 late 2000 are when we were looking at this question
9 of could we stop the study early with respect to
10 power. And we sent the statisticians back to
11 address that question and that power calculation
12 would certainly have included the dropout rate.

13 Q. What's the SAC committee?

14 A. It is a scientific advisory committee,
15 and this is typically a group of outside experts,
16 either physicians or scientists in each therapeutic
17 area that we would bring in on a periodic basis,
18 sometimes once a year, sometimes once every couple
19 of years to review our programs.

20 MR. DAVIS: Mark this please as the next
21 exhibit.

22 (WHEREUPON, said document was marked
23 Leiden Deposition Exhibit No. 18,
24 for identification, as of 4/26/07.)

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1 A. Yes, I do see it.

2 Q. Do you recall making that presentation?

3 A. No, I don't.

4 Q. But again --

5 A. But again, just, I assume, and I am

6 speculating here to some extent, that that

7 presentation said exactly what the strategy

8 presentation said, which is that we don't have the

9 data, therefore, it is a question mark.

10 Q. In the SAC presentation, did you refer

11 to ABT-594 as having questionable commercial

12 viability?

13 A. I just don't -- I don't even remember

14 the presentation, so sorry, I can't tell you

15 exactly what I said.

16 (WHEREUPON, said document was marked

17 Leiden Deposition Exhibit No. 19,

18 for identification, as of 4/26/07.)

19 BY MR. DAVIS:

20 Q. Dr. Leiden, you have what's been marked

21 as Exhibit 19. It is an e-mail from Dr. McCarthy

22 to a variety of other people at Abbott that

23 references a ABT-594 partnership strategy meeting.

24 Do you see that?

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1 A. Yes.

2 Q. Why was Abbott trying to engage a
3 partner to develop ABT-594 in late 2000?

4 MR. WEINBERGER: Objection, assumes facts not
5 in evidence.

6 BY THE WITNESS:

7 A. I don't know that they were and I have
8 no idea what this means. Maybe this was just
9 talking about Hancock.

10 BY MR. DAVIS:

11 Q. Are you aware of any effort by Abbott in
12 late 2000 to find a partner in the pharmaceutical
13 industry to help co-develop ABT-594?

14 A. Only the -- the only one I am aware of
15 is the way Hancock was a partner, if you want to
16 think of that way.

17 Q. Did you understand Hancock to be
18 co-developing ABT-594?

19 A. No, sorry, that's not what I said. Does
20 this say "co-development"? I didn't see that it
21 said that. You were pointing me to the top
22 paragraph. That's the only part I read.

23 Q. If you look under Potential Partners
24 about part of the way down the page, those are all

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1 pharmaceutical companies, correct?

2 A. No, "others" isn't a pharmaceutical

3 company.

4 Q. It could be?

5 A. Could be, could be not.

6 Q. Are any of the other ones that are named

7 not pharmaceutical companies?

8 A. No, they are all pharmaceutical

9 companies.

10 Q. As you sit here today, you have no

11 recollection of any efforts by Abbott to find

12 another pharmaceutical company to partner with

13 regarding ABT-594?

14 A. I don't, no.

15 Q. Would people within your organization

16 have undertaken an initiative to identify a

17 co-development partner in the pharmaceutical

18 industry for ABT-594 without your permission?

19 A. They obviously did, because I don't

20 remember giving them permission.

21 Q. You think it was done without your

22 authorization?

23 A. I am not aware of authorizing this. By

24 the way, again, it likely reflects what we talked

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1 A. I don't know that.

2 Q. Did you ever hear about any discussions
3 between Abbott and Purdue concerning ABT-594?

4 A. I didn't.

5 Q. Did you ever hear about any discussions
6 between Abbott and Pharmacia concerning a potential
7 partnering relationship involving ABT-594?

8 A. I don't recall that.

9 MR. DAVIS: Let's mark this as the next
10 exhibit.

11 (WHEREUPON, said document was marked
12 Leiden Deposition Exhibit No. 20,
13 for identification, as of 4/26/07.)

14 BY MR. DAVIS:

15 Q. Dr. Leiden, this is another project
16 status report for ABT-594. This one dated from
17 December 2000. The very first item says "Closing
18 of enrollment on M99-114 as of January 5, 2001."
19 Do you see that?

20 A. Yes, I see it, yes.

21 Q. That's the -- we discussed earlier a
22 decision was made at some point in time to end
23 enrollment in that trial at less than 320 patients,
24 correct?

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1 A. Yes, it was.

2 Q. And you participated in that decision?

3 A. I did.

4 Q. Did you make that decision? Were you

5 the one who were called upon to make that final

6 decision?

7 A. Yeah, again, the decisions of this

8 nature were typically made by the PEC, which was

9 this group of leadership to whom these things were

10 presented. And then our basis for making decisions

11 was typically to reach consensus on those

12 decisions, and my memory about this is that we did

13 reach such consensus.

14 Q. PEC, as a group, decided to end that

15 enrollment early?

16 A. Yes.

17 Q. Is there some record of the PEC meetings

18 that would show that?

19 A. I don't know.

20 Q. Were records kept of PEC meeting

21 decisions?

22 A. They typically were kept.

23 Q. In what form did you typically see them?

24 A. They were typically prepared by either

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1 some of the funds, likely the only thing that would
2 appear here is the Abbott funds. And so, because
3 this is an Abbott budget.

4 Q. This is Abbott's planned spending?

5 A. Correct.

6 MR. DAVIS: Let's mark this as the next
7 Exhibit, please.

8 (WHEREUPON, said document was marked
9 Leiden Deposition Exhibit No. 22,
10 for identification, as of 4/26/07.)

11 BY MR. DAVIS:

12 Q. A few minutes ago, Dr. Leiden, you
13 referred to the final plan. You will see that this
14 is a document from a Matt Russell in finance that
15 contains the 2001 plan final reference package. Do
16 you see that?

17 A. Yes.

18 Q. Do you recall seeing, either this
19 document or documents in this format when you
20 worked at Abbott?

21 A. This isn't probably what -- well, parts
22 of this would be given to me, but this probably has
23 a lot more detail than what I would usually see.
24 So I would usually get a summary, with a summary

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1 P&L and maybe a project list of expenses. So this
2 is considerably more detailed than typically I
3 would get.

4 Again, I am not really sure what this
5 is. This was March 2nd. So this is likely close
6 to the final that was approved, because we are
7 already into the year.

8 Q. It is referenced as the final plan?

9 A. Again, I want to be careful there,
10 because there were lots of things that were called
11 "final."

12 For instance, there was a final
13 development plan, which then got put together with
14 the final discovery plan, to make the final R&D
15 plan. Changes were made in between there.

16 There was a final pharmaceutical
17 products group plan that got submitted to
18 corporate, and then sometimes there were changes
19 made at corporate. So what you call final often
20 went on for an awfully long time before it became
21 final. I just don't know.

22 But here we are into 2001 because it
23 says "Data as of February 2001." So we are
24 approaching the final plan here, if it is not the

1 final.

2 Q. At some point in time they have to reach

3 a final plan for before the year is over, right?

4 A. You would be surprised. This rolled

5 into what was called the April update, which was

6 our next review of this where there were more

7 changes made. So you are right. I mean, we did

8 reach a final plan.

9 My only point was it was a fairly

10 dynamic process, and there were lots of changes,

11 and so you have to be careful when you reference

12 final plans they were really a final plan.

13 Q. This is the final plan as of March?

14 A. As of February 16, yeah.

15 Q. If you take a look first at the page

16 that's marked -- actually these pages are numbered,

17 I will give you the Bates No. 7567. It is about

18 two-thirds of the way into the package. Bates

19 number ends at 7567.

20 A. Yes.

21 Q. There is a pharmaceutical research

22 expense breakdown 2001 plan. Do you see that?

23 A. Yes.

24 Q. And first, I want to point out, it was

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1 under neurology. You see there is a reference to

2 ABT-594?

3 A. Yes.

4 Q. You see it says "formerly CCM"?

5 A. Got it.

6 Q. And so you see that that's 594 and CCM

7 were the same thing within the Abbott system, is

8 that right?

9 A. Well, again, I don't actually remember

10 that, but it certainly looks that way from here so

11 I am willing to take your word for it. I just

12 didn't know it was called CCM.

13 Q. Would you turn to the next page in that

14 document. There is a summary of R&D projects 2001

15 plan.

16 A. Yes.

17 Q. Second box down there is a reference to

18 ABT-594.

19 A. Yes.

20 Q. And so we have, there are columns that

21 follow that. One is Cost Through 2000. And am I

22 correct that that -- it says 62.2 million.

23 That's the amount of Abbott's spending

24 on that particular compound through 2000?

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1 A. Again, that's how I would interpret

2 this, but I never really saw this document, but

3 that's a reasonable interpretation of this.

4 Q. And then there is a reference to 2000

5 actual, which you would understand to be the amount

6 actually spent by Abbott on that compound in the

7 year 2000?

8 A. Yes.

9 Q. And these plans are geared towards

10 calendar years, is that correct?

11 A. Yes, yes.

12 Q. Then the 2001 plan has 9.3 million,

13 correct?

14 A. Yes.

15 Q. So is it fair to say as of the date that

16 this document was prepared, Abbott planned on

17 spending 9.3 million on ABT-594 in 2001?

18 A. Yes, but again, I want to just make you

19 aware of how that spending is done in these plans.

20 We do what's called plan for success, for reasons I

21 will explain in a minute.

22 So for instance, in this case, actually

23 an interesting one, my assumption is -- and I would

24 have to go back and look at the documents. This is

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1 how we would typically do it.

2 We would have assumed that the 594 Phase

3 IIb trial, the one we have been talking about,

4 neuropathic pain, was going to be successful, was

5 going to give a go decision. Then we would budget

6 for the entire year for the next part of that

7 project.

8 Of course, the reason we did that is we

9 didn't want to get caught short if a project

10 succeeded and we didn't have the funds to develop

11 it. So my assumption is that likely the \$9.3

12 million reflected the estimated costs, assuming

13 that the Phase IIb trial was positive.

14 And if it was negative, there would be

15 some cost savings associated with that that we

16 would go back and then later recalculate.

17 Q. Okay. You see if you take a look at the

18 Page 7542.

19 A. Yes.

20 Q. Reference there again to ABT-594, do you

21 see that?

22 A. Yes.

23 Q. It says "Milestone funded to go/no go

24 decision June 2001 for neuropathic pain."

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1 A. Yes.

2 Q. That's the under the column entitled

3 "In," do you see that?

4 A. Yes.

5 Q. That means that what Abbott did as of

6 March -- February 2001 was it had funded ABT-594 up

7 to that go/no go decision, correct?

8 A. That's my interpretation of this.

9 Again, I didn't prepare this, but that's

10 reasonable.

11 Q. Then under "Out," you see "Funding for

12 third and fourth quarters, if go decision is made"?

13 A. Yes.

14 Q. And so am I correct that at that point

15 in time Abbott had not funded anything beyond that

16 go/no go decision?

17 A. That's what it looks like here, yes.

18 Q. Do you know whether any information

19 about any revisions in Abbott's planned spending

20 for ABT-594 were given to John Hancock before the

21 research funding agreement was signed?

22 A. I am not sure which changes you are

23 talking about.

24 Q. Well, if you would go back and take a

1 during the course of his deposition.

2 MR. WEINBERGER: You have all the information.

3 You have all the information. I have told you

4 everything I know.

5 MR. DAVIS: As I mentioned, it has come out

6 for the first time right now.

7 MR. WEINBERGER: Your request for admission

8 was served and the response was due tomorrow. So

9 that's -- we have complied with our obligations.

10 MR. DAVIS: When I get that information, I

11 will reserve my rights. If I have to question

12 Dr. Leiden about it, I will let you know.

13 MR. WEINBERGER: I have told you all the

14 information I have. He doesn't know anything about

15 the inner workings of the Abbott computer system

16 metadata. If there is some question you want to

17 ask him about what I have told you, ask him.

18 BY MR. DAVIS:

19 Q. Dr. Leiden, McKinsey -- who at McKinsey

20 was involved in the March 2001 portfolio review?

21 A. I can't tell you that. There were 200

22 people in the room, including a whole team. I

23 think probably the whole team of consultants from

24 McKinsey.

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1 Q. 200 people in the room?

2 A. At least.

3 Q. How many were Abbott people?

4 A. The majority of them were Abbott people.

5 Q. How many of them took notes?

6 A. I have no idea.

7 Q. Is there a listing of the Abbott people

8 who attended the prioritization, the portfolio

9 review?

10 A. I am sorry, I don't know that.

11 Q. Typically, there would be some sort of

12 invitation list generated by Abbott concerning the

13 number of people who -- or the people who attended

14 a portfolio review?

15 A. No, because this one was a different

16 kind of portfolio review. Since every project was

17 getting presented, literally people in teams were

18 coming in and out of the room all day, for actually

19 two days, I think it was, or three days, so there

20 was a big room with a couple of hundred seats and

21 people were coming in, they'd do their

22 presentation, they'd sit and listen, and they'd go

23 out, so it was a very large number of people.

24 Q. Did you take notes during the portfolio

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1 Q. You yourself have never undertaken any
2 search?

3 A. No.

4 MR. WEINBERGER: By "this" I mean Exhibit 7,
5 for the record.

6 BY MR. DAVIS:

7 Q. How did people get invited to the
8 March 7 through 9, 2001 portfolio review?

9 A. Again, I have a fairly vague memory of
10 this, but in addition to the PEC members, who I
11 told you about who were invited because they were
12 part of PEC, every development team was invited to
13 present their work. And I believe that came
14 probably through Dr. Leonard's office.

15 Q. What room was the review conducted in?

16 A. It was at a hotel -- it was at the Hyatt
17 Deerfield.

18 Q. Was the review recorded in any way?

19 A. I don't remember it being recorded, no.
20 When you say "recorded," again, you mean like
21 electronically taped?

22 Q. In any form.

23 A. I don't remember it being recorded in
24 any form.

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1 Q. Who was responsible for keeping track of
2 the events at the review?

3 A. I don't remember that for that review.

4 Q. There has been reference made to
5 McKinsey. McKinsey is a consulting firm, correct?

6 A. Yes.

7 Q. Had Abbott retained McKinsey as of
8 March 2001 to assist it in some way in the
9 portfolio review?

10 A. Not in the portfolio review, per se. In
11 the Knoll integration, so there were a large number
12 of McKinsey consultants who participated in all the
13 various aspects of the Knoll integration. In many
14 ways, one could think of this as a part of the
15 Knoll integration.

16 MR. DAVIS: Mr. Weinberger, if I understand it
17 correctly you said you are going to tell me in
18 responses to request for admission that this
19 document, Exhibit 7, is dated March 8th?

20 MR. WEINBERGER: I believe that's correct.
21 Not that the document is dated March 8. That's the
22 entry for the, I think, for the creation date.
23 When you look at the megadata, it tells you what
24 the date is of creation and that's the best we have

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1 20 or 30 people.

2 Q. For McKinsey?

3 A. For McKinsey. It was a whole team. The

4 I don't know the precise number.

5 Q. Who at Abbott was primarily responsible

6 for interacting with the folks at McKinsey?

7 A. It was a guy name Xavier Frapaise.

8 That's not fair. Bill Dempsey ran the entire --

9 I am misspeaking now. Joel Nemmers ran the entire

10 integration, Joe J-o-e, N-e-m-m-e-r-s. So he was

11 sort of the formal Abbott team leader for the

12 entire integration. And I believe Xavier Frapaise,

13 F-r-a-p-a-i-s-e, was the subteam leader for R&D.

14 Q. Does Mr. Frapaise still work at Abbott?

15 A. I know he doesn't. He went to TAP and

16 then I believe he was working at a biotech company

17 somewhere. I am not sure now.

18 Q. How about Joe Nemmers?

19 A. Joe does still work for Abbott, I

20 believe. I haven't been there for a year, so as of

21 the time I left Abbott Joe worked at Abbott but I

22 haven't followed up with him.

23 Q. Besides Exhibit 7, was there any written

24 work product that McKinsey ever delivered to Abbott

1 with respect to the Knoll integration?

2 A. I am sure there were, but I can't tell

3 you what they were.

4 Q. Where would you look for those

5 materials?

6 A. I really don't know. That was, again,

7 this was being run by a whole team, so I don't know

8 what documents -- I didn't tend to review those

9 documents or see them.

10 Q. Why was it that Abbott had McKinsey

11 people attend this March 7 through 9, 2001

12 portfolio review?

13 A. In general, McKinsey people attended

14 all -- everything to do with the Knoll integration.

15 As I said, this was one facet of many, many facets

16 of the Knoll integration, so they had a whole team

17 and they tended to go to all the manufacturing

18 things, commercial things, the R&D things. There

19 were many pieces of this integration.

20 Q. Was one of McKinsey's responsibilities

21 to keep records of what occurred at the portfolio

22 review?

23 A. Not to my knowledge. They were not

24 assigned to do that at least by me.

1 Q. You are sure of that?

2 A. By me, I am absolutely certain of that.

3 Q. But you said they may not have been

4 assigned by you. Do you know whether one of their

5 responsibilities was it keep track of the events at

6 the portfolio review?

7 A. I don't know that. As I said, they were

8 not assigned by me to do that.

9 Q. They may have been assigned by someone

10 else?

11 A. I don't know.

12 Q. Were you generally the person giving

13 instructions to McKinsey at that point in time?

14 A. No.

15 Q. Do you recall receiving anything else

16 from McKinsey aside from Exhibit 7? Do you recall

17 receiving anything at all from McKinsey with

18 respect to the March 7th through 9th, 2001

19 portfolio review?

20 A. I don't recall receiving anything with

21 them with respect to that review, and as I said,

22 I have never seen this document.

23 Q. After the March 7 through 9th portfolio

24 review, there were further meetings at Abbott

1 group within Abbott, right?

2 A. Right.

3 Q. Did DSG provide you with any additional
4 information or analysis in advance of the March 7
5 through 9th portfolio review?

6 A. I don't remember receiving any.

7 Q. Does Abbott maintain records of
8 portfolio reviews it conducts?

9 A. Again, I am not the right person to ask
10 for that. We have a records department and I am
11 not sure how the records are maintained.

12 Q. Is that RIC, R-I-C?

13 A. I don't know. I am sorry I just don't
14 know the details of that. I know there is a
15 records department at Abbott. I did not maintain
16 records of these reviews typically.

17 Q. Going back to the point in time at the
18 end of the portfolio review on the March 7 through
19 9, when you actually went ahead and prioritized the
20 various compounds, as best you recall, who
21 participated in that particular part of the
22 process?

23 A. That was the PEC, as I recall it.
24 People I told you about before.

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1 Q. Were all the members of the PEC at the
2 portfolio review?

3 A. Again, I just don't have that level of
4 detail. It was a long time ago.

5 Q. How long --

6 A. Sorry, just to -- in addition, I think
7 there were some members like, for instance, Bob
8 Cayman, who ran ABC, who might not have been on the
9 PEC but participated in that final process because
10 he was from the Knoll side of things.

11 Q. The agenda we see there, what exhibit
12 number is that, please?

13 A. It is 5.

14 Q. Now, when in the portfolio review
15 meeting process did you have that discussion in
16 which the members of the PEC actually went about
17 prioritizing the various compounds?

18 A. Again, I don't remember the specifics,
19 but typically it would be at the end, so that would
20 have been Friday afternoon.

21 Q. Well, according to the agenda that's
22 been marked as Exhibit 5, it shows that the last
23 presentation began at 4:05 p.m., and the conclusion
24 was at 4:25 p.m.

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1 Is it your recollection that you met
2 after that conclusion of the presentations at 4:25?
3 A. It is not my recollection. I just can't
4 remember. My recollection is we did have a meeting
5 with the PEC. That would typically occur at the
6 end, but I can't tell you what time of the day or
7 which day it was. That was six and half years ago.

8 Q. If I recall correctly, March 9 is a
9 Friday.

10 A. According to this, it says it is a
11 Friday.

12 Q. Did you meet that weekend?

13 A. I don't remember meeting. I just can't
14 tell you the time, I am sorry. It is just too long
15 ago to remember. I remember we had a meeting to
16 talk through the projects and assign homework
17 assignments, but I don't remember when the meeting
18 was.

19 Q. Do you remember sometime either in the
20 course of or shortly after the portfolio review
21 ended that instructions were given to the members
22 of the 518 team to halt development activities?

23 A. Did you say 594?

24 Q. No, I said 518.

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1 A. Can you repeat the question? You

2 shifted gears on me there.

3 Q. Certainly. Do you recall that either

4 during or shortly after the portfolio review

5 meeting on March 7 through 9th ended that

6 instruction was given to the members of the ABT-518

7 team to halt further development of that compound?

8 A. So, I only remember because of some of

9 the documents I reviewed yesterday, and so they

10 refreshed in my memory, which is still somewhat

11 vague, that what happened with 518 is the project

12 was put on hold, meaning don't enroll any more

13 patients or do any more work somewhere within --

14 shortly thereafter the review.

15 And then I believe, again, based on my

16 review of the documents yesterday, that John

17 Leonard and maybe Perry Nissen, who was running the

18 oncology group, because 518 was an oncology

19 compound, came to see me and basically convinced me

20 that, A, we wouldn't save a lot of money by putting

21 518 on hold and we could save a lot time if we left

22 the study running.

23 So I think my memory of what happened is

24 we put it on hold sometime soon after the meeting,

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1 and within a few days, again I can't give you the
2 exact timing, those guys came to see me and we
3 said, "Okay, let's just continue it."

4 MR. DAVIS: Let's mark this as the next
5 exhibit please.

6 (WHEREUPON, said document was marked
7 Leiden Deposition Exhibit No. 30,
8 for identification, as of 4/26/07.)

9 BY MR. DAVIS:

10 Q. Dr. Leiden, I will show you what's been
11 marked as Exhibit 30 and represent to you that this
12 is a timeline that was put together by other Abbott
13 personnel concerning. It says "Timeline of events
14 occurring with the study M00-235 in the
15 Netherlands," which was the Phase I study of
16 ABT-518.

17 According to this timeline, Dr. Nisen
18 and Dr. Nabulsi attended Abbott senior management
19 review on the 7th of March 2001. Do you see that?

20 A. Yes, I see it, March 7, 2001, yes.

21 Q. And if we look back at the agenda for
22 March 7, 2001, we see that 518 is listed as being
23 on the agenda that day beginning at 1:25 p.m.,
24 correct?

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1 A. Yes.

2 Q. And Dr. Nisen was listed as -- is that

3 the presenter?

4 A. I believe so, yes.

5 Q. And it says that according to this

6 timeline, that was put together by people at

7 Abbott, it says that on March 11, 2001, "Nabulsi

8 calls Looman, assistant medical director oncology,

9 to inform about immediate stop ABT-518 project."

10 Do you see that?

11 A. That's what it says, yes.

12 Q. So the order that came down was an

13 immediate stop to the ABT-518 project, correct?

14 A. The order that came down from Nabulsi is

15 that what you are talking about?

16 Q. Is it correct that someone above

17 Dr. Nabulsi informed him to stop the ABT-518

18 project, correct?

19 A. Again, my memory of this, and the only

20 thing I remember that I was involved in, is the PEC

21 at some point very soon after the meeting, either

22 immediately afterwards or soon afterwards, decided

23 to put 518 on hold, which means don't enroll more

24 patients.

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1 Again, within a couple of days, I spoke
2 with Leonard and I believe Nisen was there, Perry
3 Nisen was there, too, and they convinced me that
4 that would not save us a lot of money, and actually
5 that if we continued until we saw the ASCO date on
6 other compounds, that we would save ourselves some
7 time, and so we as a group decided to continue the
8 study and that was reversed. That's my memory of
9 518.

10 Q. So it is not your memory that anyone
11 within Abbott was instructed to halt all
12 development activities involving ABT-518, is that
13 correct?

14 A. My memory is that the project was put on
15 hold, which meant do not enroll more patients in
16 the study, which is MOO-235.

17 I have a vague memory that there were a
18 couple of patients enrolled who actually continued
19 rolling through the study, but no new patients were
20 enrolled. That's my memory of this, for the couple
21 of days, that's what the direction was.

22 And then within a couple of days, we
23 decided to continue the study and it was continued.

24 Q. Now, the timing of this, though -- by

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1 the way, you know Dr. Nabulsi?

2 A. I think I met him once, I know Dr. Nisen

3 but I think I only met Nabulsi once or twice.

4 Q. You would agree with me that Dr. Nabulsi

5 is probably in a better positioned than you are to

6 better understand sort of the competitive data that

7 was available at the time concerning ABT-518 and

8 other MMPI compounds?

9 MR. WEINBERGER: Object to the form of the

10 question.

11 BY THE WITNESS:

12 A. I can't comment on that because I don't

13 know Nabulsi well enough to comment on his

14 expertise.

15 BY MR. DAVIS:

16 Q. Do you know what competitive data, what

17 information was available to Abbott as of March 7th

18 through 9th of 2001 concerning what potentially

19 competing compounds existed and how their

20 development was progressing?

21 A. Yes, so again, what I know and what I

22 remember is there was conflicting data about this

23 class of compounds, which are called MMPis, matrix

24 metalloproteinase inhibitors. That is class of

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1 compounds that was extremely hot, meaning there was
2 a tremendous amount of interest from the pharm
3 industry in the mid '90s until early 2000s. There
4 must have been 20 or 30 products being developed,
5 including one or maybe several at Abbott.

6 We were generally behind many of the
7 other companies who already had products up in
8 Phase II and Phase III. And what had happened in
9 the late '90s and very early 2000 was that there
10 was some mild efficacy data shown for these
11 compounds by several different companies, and at
12 the same time there was side effect data that was
13 beginning to accumulate around a couple of
14 different side effects, particularly joint pains,
15 by a couple of different companies. A couple of
16 companies actually stopped the development based on
17 that.

18 And so the question that we faced at the
19 time was, was the side effects -- were the side
20 effects that were being seen class effects, that
21 is, would they be true of all compounds, or would
22 it be possible to develop a compound in this class
23 that was selective and potent enough it could
24 inhibit the enzymes that lead to cancer invasion

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1 and, therefore, treat cancer and at the same time
2 not have these side effects.
3 Just at the time when this review was
4 happening and we were discussing this, there was
5 tremendous amount of controversy over that. What
6 was presented at the review was that within three
7 to five months, there would be a series of
8 presentations in what was called the ASCO meeting,
9 which is the big cancer meeting in the spring and
10 summer, on competitor compounds that were ahead of
11 us that were being given in multiple Phase II and
12 phase III trials. And based on the results of
13 those presentations, we thought that we would have
14 a lot more information about whether there were --
15 this joint effects and side effects were class
16 effects or whether they were, in fact, specific to
17 the individual compounds, and therefore, whether it
18 be would possible to take our compound, which was
19 more potent and which was slightly more selective
20 than many of the other compounds were. So that's
21 where we were.

22 My memory of this is there was a brief
23 discussion, but the discussion around this at the
24 portfolio review meeting was "Okay. Given this, we

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1 are going to get all this data for free from other
2 companies in April, May, June, at the ASCO
3 meetings, should we continue our program until we
4 get that data or should we put our program on hold
5 until we get that data?"

6 As I said, the initial decision was,
7 "Let's put our program on hold. It is just
8 starting. Wait until we get that data and then
9 decide to take it forward."

10 Nisen and Leonard came to see --
11 Leonard, I think Nisen also came to see me several
12 days later and said, "Hey, we can continue the
13 program for a very low cost. We will save all that
14 time and we will still get the data free in April
15 and May, and then we can decide to stop it if we
16 see the wrong data at that point which suggests
17 that our compound won't be developable or
18 competitive," so I agreed to that and we started
19 the program again.

20 Q. You referred to putting the program on
21 hold. In fact, what you were doing was killing a
22 clinical trial that was underway correct?

23 A. Stopping, not killing. This is my
24 memory of it. Again, it is a little vague. My

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1 Q. Now, again, Dr. Nabulsi was aware as of
2 March 11, according to this timeline, of the
3 decision to immediately stop the ABT-518 project.

4 Who was it that conveyed that
5 information to him?

6 A. That I don't know.

7 MR. WEINBERGER: Objection.

8 BY MR. DAVIS:

9 Q. And if the 9th was the Friday, and the
10 11th was Sunday, was there information being handed
11 out to project team managers regarding the fate of
12 their projects over the course of the weekend
13 following the portfolio review?

14 A. I just don't know that. I don't know
15 how the communications were handled.

16 Q. Are you the person who made the final
17 decision to halt or stop the ABT-518 project in
18 early March 2001?

19 A. As I said, those decisions, if you are
20 talking about the decisions around the portfolio
21 review, were made by the PEC. I chaired the PEC.

22 Q. Were you in favor of that decision?

23 A. Yes. When it was initially made, yes.

24 Q. Were you aware there was already a

1 Phase I trial underway?

2 A. I believe I was.

3 Q. And you were aware that it would be

4 necessary to -- were you aware it would be

5 necessary to essentially scrap that trial and begin

6 again?

7 A. No, that wasn't my -- as I say, based on

8 my review of the documents, that wasn't my

9 understanding.

10 My understanding was that we would put

11 the trial on halt, allow patients who were in it to

12 continue, and then based on the ASCO results decide

13 to continue or not.

14 Q. You recall there was a discussion about

15 ASCO at the portfolio review on March 7 through 9.

16 A. That's my memory, that data was

17 presented on a couple of compounds, which was

18 contradictory. And then what was talked about, and

19 certainly what Leonard and Nisen talked to me about

20 was, "Look, we are going to have all this

21 additional data at ASCO, and then we will really

22 know."

23 Q. When Leonard Nisen spoke to you, they

24 also spoke to you about John Hancock, didn't they?

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1 A. No.

2 Q. Dr. Leonard didn't mention to you that

3 the John Hancock deal was pending?

4 A. In that discussion?

5 Q. Yes.

6 A. No, I don't remember him talking or

7 saying anything about Hancock. This was all about

8 518.

9 Q. Do you recall him mentioning anything to

10 you about how now Abbott had a partner in John

11 Hancock with respect to ABT-518?

12 A. I don't remember that, sorry.

13 Q. So did the fact that the Hancock deal

14 was pending, was going to be signed shortly,

15 have -- play any roll in the decision to recommence

16 the expenditures of the ABT-518 project?

17 A. Not to my knowledge, no.

18 Q. Now, if you take a look at Exhibit 7 for

19 a moment on the second page, the reference to

20 ABT-518.

21 Now, based on the information that you

22 have now, Dr. Leiden, is it your understanding that

23 Exhibit 7 is McKinsey's, sort of, summary of events

24 at the March 7 through 9th 2001 portfolio review

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1 meeting?

2 A. Again, I don't --

3 MR. WEINBERGER: Excuse me. Object to the

4 form of the question. Go ahead.

5 BY THE WITNESS:

6 A. I really don't know who prepared this or

7 what it was for. As I said, the only data that's

8 available is this, I can't recall, meta data,

9 whatever it is called.

10 BY MR. DAVIS:

11 Q. Was there another meeting in, say, the

12 first quarter of 2001 in which Abbott senior

13 management decided to put a hold on the development

14 of ABT-518?

15 A. Again, my recollection of this it was

16 after this meeting that we decided to put the hold

17 on 518.

18 Q. Now, this particular document on Page 2

19 under Priority, it says, "Hold/T." Do you see

20 that?

21 A. Yes.

22 Q. Do you see, again, "T" stands for

23 terminate, correct?

24 A. That's what it says up at the top, yes.

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1 Q. And it also says, "Halt all further
2 expenditure." Do you see that?

3 A. Yes.

4 Q. Now, "halt all further expenditure"
5 that's consistent with your understanding of what
6 Abbott personnel were being instructed to do as of
7 this point in time, is that right?

8 MR. WEINBERGER: Objection, mischaracterizes
9 his testimony, asked and answered.

10 BY THE WITNESS:

11 A. No, it is not my understanding of it.
12 My understanding of it was, again, we would stop
13 further enrollments, but we would allow patients
14 enrolled to continue, which would probably have
15 some cost associated with it, in other words.

16 BY MR. DAVIS:

17 Q. And then do you recall discussion in the
18 March 7 through 9th portfolio review about
19 terminating ABT-518?

20 A. No. What I recall is the discussion to
21 put it on hold until we saw the ASCO results,
22 which, by the way, is consistent, as it so happens,
23 with what's written down here, "Wait for May
24 results" -- May results refers to the ASCO results

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1 from Pfizer -- "and reevaluate."

2 Q. The "halt all further expenditure," you
3 say, is not consistent, correct?

4 A. Correct, not with my understanding.

5 Q. And how about the "T," terminate, is
6 that?

7 A. That's also not consistent. The "hold"
8 is consistent with my recollection.

9 Q. But the "T" isn't?

10 A. Correct. I am not sure how you can both
11 hold and terminate, so it is confusing to me.

12 Q. Did you believe at the time you were
13 putting 518 on hold that you were likely to
14 terminate it?

15 A. No. We were likely to wait until these
16 results from ASCO. There was actually good reason
17 at the time to think that our compound was more
18 potent and more selective than the competitor
19 compounds, and that it could get around the side
20 effects, et cetera.

21 As it turns out, in retrospect, this was
22 a class effect. And as you increase the potency
23 around the effectiveness, you also increased the
24 side effects. And moreover, as it turns out, the

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1 MMPIs, as a class, had very limited efficacy. So
2 to my knowledge, I think all MMPI programs over the
3 next two or three years were terminated, so
4 actually it was the right decision once we saw the
5 ASCO data.

6 Q. Did ABT-518 suffer those same problems?

7 A. We never got far enough in the trial to
8 know that, but since all the rest did, it was a
9 quite -- more than a reasonable assumption that 518
10 would.

11 Q. Looking at the timeline that's been
12 marked as Exhibit 30, under the March 7th, 2001
13 entry, it says, again, "Nisen and Nabulsi attended
14 Abbott senior management review, ('concern
15 regarding the continuation of ABT-518
16 development'.)"

17 A. Yes.

18 Q. What were the concerns about the
19 continuation of ABT-518 development at that point
20 in time?

21 A. This is, again, based around the fact
22 that the data shown at that review for several
23 other compounds was contradictory. There was some
24 efficacy shown, but there were also side effects,

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1 particularly, joint pain that was seen in several
2 compounds, and so it wasn't clear to us whether our
3 increased potency and increased selectivity would
4 allow us to get around that or not.

5 MR. DAVIS: Okay. I am going to shift gears
6 on you, again, Dr. Leiden. We are going to talk
7 about 519 again. Would you mark that as the next
8 exhibit.

9 (WHEREUPON, said document was marked
10 Leiden Deposition Exhibit No. 31,
11 for identification, as of 4/26/07.)

12 BY MR. DAVIS:

13 Q. Dr. Leiden, do you have in front of you
14 a document that's marked as Exhibit 31? And you
15 see that these are a string of e-mails between,
16 among others, Dr. Verlinden, and also on the second
17 page you see the very first e-mail is one from
18 Dr. Leonard to Dr. Verlinden. Do you see that?

19 A. Actually, just again to clarify, my
20 first page looks to me like the first e-mail is
21 from James Thomas to Yiming Zhang.

22 Q. I call it the first e-mail because they
23 are reversed. The string is usually the most
24 recent e-mail is on the top.

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1 that discussion, yes, I was present for it. But
2 you handed me a 110-page document, so I would have
3 to look through the whole thing to tell you whether
4 this was actually -- if I could remember this as
5 that discussion.

6 MR. WEINBERGER: 125.

7 BY MR. DAVIS:

8 Q. Do you recall any discussion at that
9 meeting concerning the dropout rates in the
10 Phase IIb study?

11 A. Yes, I recall discussions concerning
12 both dropout rates and nausea, vomiting, and
13 dizziness side effects.

14 Q. Do you recall any discussion about how
15 the dropout rates in the Phase IIb study for 594
16 compared to dropout rates in clinical trial studies
17 conducted on other comparable compounds?

18 A. I don't recall that. So I would have to
19 look through the document to see it.

20 (WHEREUPON, said document was marked

21 Leiden Deposition Exhibit No. 33,

22 for identification, as of 4/26/07.)

23 BY MR. DAVIS:

24 Q. You have what's been marked as

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1 Exhibit 33 of your deposition, again, a couple of
2 e-mails or series of e-mails. The bottom one
3 appears to be the first in time. It is from a
4 Howard Cheskin to a variety of people dated
5 October 9, 2001. Do you see that?

6 A. Yes, I do.

7 Q. Who is Howard Cheskin?

8 A. I have no idea.

9 Q. The e-mail itself states, "An outcome of
10 yesterday's pharmaceutical executive committee
11 meeting was to kill ABT-594. There will be
12 attempts to outlicense the compound since the
13 risk/value assessment came up with a positive net
14 present value, but it will not be developed by
15 Abbott." Do you see that?

16 A. Yes.

17 Q. Is it true that as of October 2001 that
18 Abbott believed that ABT-594 had a positive net
19 present value?

20 A. I just don't remember. I would have to
21 review the documents.

22 Q. What efforts were made by Abbott after
23 they decided to kill the investment ABT-594 to
24 outlicense that compound?

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1 A. Again, I am just not the right person to
2 ask that. That would have been delegated to the
3 business development group that was run by Jim
4 Tyree.

5 Q. Did Mr. Tyree ever report to you
6 concerning his efforts to outlicense ABT-594?

7 A. I don't recall that.

8 Q. Did you ever ask Mr. Tyree what, if
9 anything, he was doing to outlicense ABT-594?

10 A. I don't recall asking him.

11 MR. DAVIS: Mark that is the next exhibit,
12 please.

13 (WHEREUPON, said document was marked
14 Leiden Deposition Exhibit No. 34,
15 for identification, as of 4/26/07.)

16 BY MR. DAVIS:

17 Q. Dr. Leiden, Exhibit 34 is a compilation
18 of a variety of reports that were sent to you --
19 appear to have been, at least, addressed to you by
20 Mr. Tyree and some others concerning highlights.
21 Is the way they are typically described?

22 A. Yes.

23 Q. Do you recall receiving reports like
24 this from your subordinates while you worked at

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1 Exhibit 34, it is the second page of a memo that
2 Mr. Tyree sent to you in a memo of 2002. Do you
3 see that?

4 A. Are you talking about Page 8030?

5 Q. Correct.

6 A. Yes.

7 Q. You see under "High Priority
8 Outlicensing," there a reference to ABT-773? Do
9 you see that?

10 A. There is a whole bunch of things.

11 MR. WEINBERGER: Where are you?

12 BY MR. DAVIS:

13 Q. Right under "High Priority"?

14 A. Yes, I do.

15 Q. There is a reference to ABT-773. Do you
16 see that now?

17 A. I do see it.

18 Q. The reference to -- in ABT-773, this is
19 after Abbott had decided that it was going to cease
20 further development of ABT-773, correct? This
21 is '02.

22 A. Yes, it is.

23 Q. Do you recall ever having any
24 discussions with Mr. Tyree in which you told him to

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1 make 594 a high priority outlicensing project?

2 A. I don't recall such discussions.

3 Q. Can you identify, as you sit here today,

4 any potential outlicensing party that Abbott ever

5 discussed ABT-594 with?

6 A. I can't. That would have come out of

7 his group.

8 Q. Did Abbott ever assemble any package of

9 materials or information that could be distributed

10 to potential outlicensees of ABT-594?

11 A. I don't know. Again, just to explain,

12 those are the kinds of things that were way below

13 my level in the company. And unless we had some

14 specific discussion about it, it would be very

15 unlikely that I would be involved in that or

16 necessarily even know about it.

17 MR. DAVIS: Let's mark this as the next

18 exhibit.

19 (WHEREUPON, said document was marked

20 Leiden Deposition Exhibit No. 35,

21 for identification, as of 4/26/07.)

22 BY MR. DAVIS:

23 Q. Dr. Leiden, you have what's been marked

24 as Exhibit 35, which is a letter to Mr. Blewitt

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1 from Daphne Pals at Abbott?

2 A. Yes.

3 Q. Did you know Ms. Pals?

4 A. I met her a couple of times. She was a
5 lawyer, I believe, at Abbott.

6 Q. On this letter, it is dated November 16,
7 2001. It says, "Dear Steve: This is to advise you
8 that Abbott has decided to terminate further
9 development of Abbott-594 (a drug for the treatment
10 of neuropathic pain)."

11 MR. WEINBERGER: Before we get into questions
12 about this, there is a bunch of handwriting on
13 here. I have no idea what it was, but presumably
14 it wasn't part of the letter that was sent to --

15 MR. DAVIS: That's just the form which the
16 letter was produced to us from Abbott.

17 MR. WEINBERGER: I am not quarreling. I want
18 to establish that nobody is arguing that that
19 handwriting was actually on the document that was
20 actually sent to Mr. Blewitt.

21 BY MR. DAVIS:

22 Q. The last line of the letter, sorry --
23 not the last line, "I hope you were doing well,"
24 the one before it says, "Abbott will attempt to

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1 maximize the commercial value, if any, of ABT-594
2 as required under section 4.3(d)." Did you see
3 that.

4 A. Yes.

5 Q. What did Abbott do to maximize the value
6 of ABT-594 after it discontinued development of
7 that compound?

8 A. I am not aware of what it did, sorry.

9 MR. DAVIS: Mark this, please as the next
10 exhibit.

11 (WHEREUPON, said document was marked
12 Leiden Deposition Exhibit No. 36,
13 for identification, as of 4/26/07.)

14 BY MR. DAVIS:

15 Q. Dr. Leiden, again, this document appears
16 to be a string of e-mails between Dr. Verlinden and
17 Dr. McCarthy dating from June of 2002. I will
18 direct your attention to the top e-mail on the
19 first page under -- you see where it says "New
20 Goals"?

21 A. Yes.

22 Q. It says there, "The goals you have
23 assigned are appropriate and I agree to the
24 timelines. Of my eight existing goals, however,

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1 A. Just to follow up on that answer, it
2 would have been, I guess, nice but very difficult,
3 in my opinion, to outlicense 594 or 518, given the
4 clinical data we had on 594 and the clinical data
5 that others had on MMPIs, because, as I mentioned,
6 all 20 or 30 MMPI programs, I believe, had been
7 canceled by the industry. And 594 just had a
8 profile that would make it very, very difficult to
9 outlicense.

10 (WHEREUPON, said document was marked
11 Leiden Deposition Exhibit No. 37,
12 for identification, as of 4/26/07.)

13 BY MR. DAVIS:

14 Q. I am going to shift gears again on you.
15 Now we are back to 518. Give you that warning.
16 Shifting gears.

17 A. Thank you.

18 Q. Now, you have in front of you
19 Exhibit 37, which is a report of some sort from
20 within Abbott concerning ABT-518 dated February
21 of '01. Do you see that?

22 A. Yes.

23 Q. Now, you recognize this form of report?

24 A. I believe this was an internal GPRD form

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1 that John Leonard developed to -- for him and his
2 office to keep track of R&D projects. I am not
3 certain of that. I think that's what it is.

4 Q. I take it from that answer that you did,
5 in fact, see reports in this format when you worked
6 at Abbott?

7 A. Rarely, but I have seen this form. I
8 think the time I remember seeing it is, I think,
9 John brought it to me when he developed it because
10 he, rightly so, was very proud of the fact that he
11 developed it, and so I looked at that time. But
12 this isn't something I would review regularly.

13 Q. Were these reports sent to you?

14 A. I don't know if they were, but this
15 isn't a report I would review regularly, but it is
16 a report, I think, that John would likely have
17 reviewed.

18 Q. Now, if you take a look at the third
19 page of this document.

20 A. Yes.

21 Q. You see that there is a reference there
22 to "Risk or Issue," and it says, "As several
23 competitors are in Phase II/III ABT-594 product
24 profile we will need to demonstrate advantage over

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1 other compounds, i.e., safety/efficacy." Do you
2 see that?

3 A. Yes.

4 Q. If you move to the right under column
5 Strategy/Progress, there is a reference there to
6 "Pfizer announced 8/4/00 that they were stopping
7 Phase III trials of prinomastat in advanced
8 prostate"?

9 A. Yes, two indications is my memory. They
10 may have continued it on a couple of other
11 occasions, I think.

12 Q. "In less advanced tumors," you see there
13 is the next reference?

14 A. I didn't see that.

15 Q. You were aware as of February 2001 that
16 Pfizer had announced that they were stopping Phase
17 III trials of prinomastat in advanced prostate and
18 NSCLC?

19 A. Again, I didn't remember that until we
20 reviewed documents yesterday, but that suggested
21 that I was aware of them.

22 Q. And further down in the same paragraph
23 it says, you see where it says, "Marimastat
24 development was discontinued on 2/15/01." Do you

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1 see that?

2 A. Yes.

3 Q. You were aware of that --

4 A. Again, same documents suggest that I
5 was.

6 Q. That's consistent with your recollection
7 here today?

8 A. I don't remember dates back six years,
9 but the documents would suggest I was.

10 Q. Would those -- the discontinuation of
11 those particular compounds, was that part of what
12 you had in mind when you and the rest of the PEC
13 ordered a halt in development of ABT-518 in early
14 March of 2001?

15 A. We ordered the halt based upon a set
16 of -- actually, a fairly large set of conflicting
17 data. This was a subset of that data. But the set
18 of data could be summarized as saying there were
19 several clinical trials which had reported
20 efficacy, there were several clinical trials which
21 had reported a lack of efficacy, there were several
22 clinical trials that had reported side effects, and
23 there were several clinical files that had been
24 stopped, including Rheumastat, in these Pfizer

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1 trials.

2 And taken together what that said to us
3 was the -- we couldn't be sure whether the side
4 effect profiles that were being seen with the MMPIs
5 were compound specific or class specific, and we
6 couldn't be certain whether the potency of our
7 compound and its selectivity, which appeared to be
8 better than these compounds, would let us get
9 around that without seeing more complete data set
10 from ASCO. And that was the reason for putting
11 that on hold until we had the data set from ASCO.

12 I should point out to you one other
13 thing. I am sure you know this. The announcement
14 the trials are terminated, which is typically done
15 in a press release, has very few medical or
16 scientific details in it. So the ability to draw
17 much of a conclusion from that, except that that
18 company decided for whatever reason that they
19 weren't going to continue developing the compound,
20 is very limited.

21 The only way to really get a conclusion
22 is to actually see the clinical and the scientific
23 data yourself, and that's what happened in ASCO in
24 April, May that allowed us to really analyze the

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1 data and -- a broader set of data and come to the
2 conclusion that the side effects we were seeing did
3 seem to be class specific and the efficacy was very
4 modest.

5 Q. Did you attend that ASCO conference
6 yourself?

7 A. No.

8 Q. Who attended the ASCO conference on
9 Abbott's behalf?

10 A. I am fairly certain that Perry Nissan
11 attended because he always went to ASCO, though I
12 couldn't swear to it for this particular one. And
13 usually at least two or three -- at least two or
14 three of the other project directors from the
15 oncology group would attend that meeting, so I
16 assume at least four or five people from Abbott
17 attended.

18 Q. What additional information did Abbott
19 learn at that conference that it didn't already
20 have?

21 A. Yeah, so what we learned was, again,
22 generally, because I can't recite it for you six
23 years later in detail. But what we learned was the
24 details of these clinical trials, as well as other

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1 clinical trials that said the following -- and
2 again, this was sort of presented in summary form
3 to me, so I can give you back in summary form --
4 the efficacy of the compounds was zero in a number
5 of tumor types, and even in the tumor types in
6 which there was efficacy shown, it was quite modest
7 efficacy, meaning there were some slow down of
8 tumor growth in some studies, but there is no
9 effect on mortality.

10 There was no effect on time -- what's
11 called time to progression, which is an end point
12 in cancer studies. And that the side effects and,
13 particularly, the joint pain were seen in a large
14 number of patients in multiple trials. So those
15 were the two classes of conclusions that led us to
16 think that the class of compounds was less
17 efficacious than we and others in the industry
18 thought and had class specific side effects that
19 would be very difficult to develop around.

20 Q. What's the basis for your understanding
21 that that information was new, that that was
22 learned at ASCO and not previously known by Abbott?

23 A. Two things: One is, by rule at ASCO,
24 you are not allowed to present the details of

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1 clinical trials, publish them, or talk about them
2 before you actually present an ASCO. So, sort of,
3 by definition, the details of clinical trials
4 presented at ASCO are new, because if you present
5 them before, they throw you off the program. So
6 that's one thing.

7 The second thing is just from my own
8 experience, I knew what had been presented to me,
9 for instance, in this March 7th review, and then I
10 knew what was presented to me later on, some point
11 in April or May after ASCO, and there was new data
12 that hadn't been presented before.

13 Q. Did you ever sit down with the people
14 who were working on the ABT-518 project and ask
15 them whether anything new of significance was
16 learned at ASCO?

17 A. I didn't.

18 Q. So you don't know whether they share
19 your view as to whether Abbott actually learned
20 anything new at ASCO?

21 A. You would have to ask them.

22 MR. DAVIS: Now, let's mark that is the next
23 exhibit, please.

24 (WHEREUPON, said document was marked

1 I will tell you that they were investigators
2 working on the Phase I trial "-- that we are not
3 proceeding with the trial as a result of the
4 projects reprioritization following the acquisition
5 of Knoll."

6 Is that an accurate statement that
7 Abbott was not proceeding with the Phase I trial of
8 ABT-518 as a result of the project's
9 reprioritization following the acquisition of
10 Knoll?

11 A. Again, I would give you the same answer.
12 My understanding was we were going to stop
13 enrolling new patients, continue patients that were
14 enrolled, stop the CMC and other development work
15 until we heard the results at ASCO, at which point
16 we would make a final decision on what to do, if
17 the results informed us on that.

18 Was that due to the reprioritization
19 following the acquisition of Knoll? Yes.

20 Q. Now, was John Hancock informed before
21 the research funding agreement was signed on
22 March 13, 2001 that Abbott had decided to stop
23 development activity on ABT-518?

24 MR. WEINBERGER: Objection, mischaracterizes

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1 his testimony.

2 MR. DAVIS: Let me rephrase the question.

3 BY MR. DAVIS:

4 Q. Was the decision to halt the Phase I
5 clinical trial at ABT-518, was John Hancock made
6 aware of that decision by Abbott before the
7 research funding agreement was signed on March 13,
8 2001?

9 A. I actually don't know, but since we
10 decided to start up the project again before the
11 research agreement was signed, at the time the
12 research agreement was signed, 518 was ongoing. So
13 I don't know if they were informed of that, those
14 two decisions or not.

15 Q. Do you know whether the decision to --
16 the order to actually recommence the Phase I trial
17 was sent out before or after the Hancock agreement
18 was signed?

19 A. I don't know, but my memory of this was
20 since you have refreshed my memory about the dates,
21 I think this all occurred within a period of just
22 five to seven days. So if the review was on
23 March 9 or 11th, as you showed me the e-mail
24 Nabulsi was sending, my memory of this is within

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1 five to seven days of the 9th or 10th those guys

2 had met with me and we had decided to go forward.

3 MR. DAVIS: We have to take a break now to

4 change the tape. So why don't we do that.

5 THE VIDEOGRAPHER: Going off the video record

6 at 2:40 p.m. This concludes Tape No. 4.

7 (WHEREUPON, a recess was had.)

8 THE VIDEOGRAPHER: We are going back on the

9 video record at 2:52 p.m. This is the beginning of

10 Tape No. 5.

11 MR. DAVIS: Would you mark that is the next

12 exhibit.

13 (WHEREUPON, said document was marked

14 Leiden Deposition Exhibit No. 39,

15 for identification, as of 4/26/07.)

16 BY MR. DAVIS:

17 Q. Dr. Leiden, you have what's been marked

18 as Exhibit 39, which is a couple of e-mails between

19 Mr. Deemer and Dr. Nisen dating from March of 2001.

20 Have you seen this document before?

21 A. I saw it yesterday.

22 Q. Note that the first e-mail is the one

23 from Mr. Deemer to Dr. Nisen in the morning of

24 March 20th. It says, "You probably heard that

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1 Q. If you are wrong in that respect, that
2 there were no patients who were going to continue
3 to receive drug during that trial, you would agree
4 with me that, effectively, you are halting the
5 trial at that point in time?

6 A. Pending the results we saw at ASCO, yes.

7 Q. Now, you said that you had a
8 recollection of some discussion with Dr. Leonard on
9 that point?

10 A. Yes, I believe Perry Nissan, too, I
11 believe.

12 Q. Was it the same discussion?

13 A. Yes, I am talking about one discussion.

14 Q. Where did it occur?

15 A. I think it was, as I say, it was likely
16 in my office, because usually those guys would come
17 over and see me. But I don't remember the
18 specifics of the meeting and the date and place.

19 Q. Who initiated the discussion?

20 A. I believe they did.

21 Q. "They" being Dr. Leonard, Dr. Nisen?

22 A. Yes.

23 Q. And you believe the discussion occurred
24 in your office?

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1 A. I think so.

2 Q. How long did the discussion last?

3 A. Again, I just don't remember the times

4 and the places, and so that I can't give you an

5 accurate answer to.

6 Q. As best you can recall, approximately

7 what day did the discussion occur?

8 A. Again, I can't tell you the timing. My

9 memory is it occurred several days after that

10 portfolio review, but whether it was one, two,

11 three, five, sometime within the next week. Let's

12 put it that way.

13 Q. Did it occur before or after the Hancock

14 deal was signed?

15 A. Again, I just didn't know, but I think

16 if it was in the next week, my memory is that the

17 Hancock deal was signed -- actually, this says,

18 yeah, the Hancock deal was signed, what, on the

19 14th, 15th.

20 Q. No, it was signed on the 13th, that

21 Tuesday.

22 A. It was somewhere right in that same

23 thing. Could have been right before it and it

24 could have been after, but right around then.

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1 Q. What do you recall was said to you in
2 the course of that discussion?

3 A. Yeah, the gist of the discussion,
4 anyway, I don't remember what all the specifics,
5 was, "Look, we know that the PEC decided to put 518
6 on hold until we see the ASCO results. However,
7 that will have the following effects. It will save
8 very little money."

9 Then the number I remember is
10 1 million, \$2 million after reviewing these
11 documents. "And it will have the effect of losing
12 us two to three months at least in time in the
13 study, maybe more, because we may have to put in
14 new paperwork to the RMBs which could delay us six
15 to nine months. So it will cost us very little to
16 continue. It will cost us a lot to stop.

17 "The better policy here is move forward
18 with the Phase I trial over the next two to three
19 months until we get the ASCO results and then make
20 the decision there," and I agreed with that.

21 Q. Did you understand at the time you had
22 this discussion with Dr. Leonard and Nisen that, in
23 fact, the Phase I trial already had been put on
24 hold or halted?

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1 A. That, I don't remember. I don't know

2 whether they told me that or not.

3 Q. Because a moment ago, you said you had

4 understood that it would cost a lot to stop.

5 When you say "cost a lot to stop,"

6 meaning cost a lot to stop the Phase I trial?

7 A. Cost a lot with respect to the time we

8 would lose on developing the drug. As I said to

9 you before, if you lose six to nine months in

10 developing a drug that eventually makes it, that's

11 worth tens of millions of dollars.

12 Their statement to me, their plea to me

13 was, "Look, if we stop, really stop this now, then

14 what's going to happen is we are going to have to

15 wait until we see ASCO. And assuming ASCO looks

16 good, we are going to have to restart the trial,

17 which will cost at least three months and maybe as

18 much as six to nine months. That's worth a lot to

19 us. On the other hand, if we discontinue now, I

20 think the number was around a million or \$2

21 million, which is not much in the grand scope of

22 things. And then if we get a positive signal from

23 ASCO, we are three to six, nine months ahead."

24 Q. Do I have it correct the primary reason

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1 why you decided to hold or halt that Phase I trial
2 as of early March 2001 was because you believed
3 that you could save money while you were awaiting
4 the ASCO results?

5 A. That was a primary reason, definitely.

6 Q. You also knew in that time frame,
7 though, that you were about to sign a deal with
8 John Hancock that had John Hancock giving you
9 millions of dollars towards the development of 518
10 along with other compounds, correct?

11 A. Actually, I didn't. As I said, I was
12 not really involved in the details of this
13 negotiation. This was something that was going on
14 predominantly with Arthur, Jim and John, and the
15 decisions that we made, for instance, at the
16 portfolio review really didn't reflect anything
17 about Hancock at all. We just looked at, "Here is
18 the set of projects and here is the approximate
19 costs. What is it going to cost us?"

20 Q. The decision to recommence the trial had
21 nothing do with Hancock either?

22 MR. WEINBERGER: You asked him that.

23 BY THE WITNESS:

24 A. My decision to recommence had nothing do

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1 afterwards. Once it was signed, I got an e-mail or
2 discussion. Whether that was Leonard or Arthur, I
3 don't know.

4 BY MR. DAVIS:

5 Q. Did you ever have any discussions with
6 Dr. Leonard about the fact that slowing down or
7 halting or putting on hold the Phase I trial for
8 518 could have adversely impacted the deal with
9 Hancock?

10 MR. WEINBERGER: Object to the form of the
11 question.

12 BY THE WITNESS:

13 A. Not to my recollection.

14 BY MR. DAVIS:

15 Q. Never came up?

16 A. Not to my recollection, no.

17 Q. How about did you ever have any
18 discussions with Dr. Nisen about the 518 debacle?

19 A. I don't know what he is referring to.

20 Q. So he never discussed that with you?

21 A. I don't know what he was referring to,
22 so I never discussed the 518 debacle in those sorts
23 of words or terms with him.

24 Q. Would you look again at the research

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1 funding agreement for a moment. I will direct

2 you --

3 A. Exhibit 1.

4 Q. It is Exhibit 1. Would you look at the

5 page that the Bates number ends in 8196.

6 A. Yes.

7 Q. You see, if you actually take a look at

8 8193 for a moment, a few pages before that, I just

9 want to give you the context here. You see that

10 that is descriptive memo for ABT-518?

11 A. Yes.

12 Q. And this is attached as an exhibit to

13 and incorporated into the agreement.

14 A. Okay. I see.

15 Q. You can confirm that, but in looking at

16 the page that ends 8196, you see there is a

17 reference there to "compounds in development"?

18 A. Yes.

19 Q. It says at the end of that paragraph,

20 "Companies with compounds in advanced chemical

21 development for the treatment of cancer include

22 Agouron/Warner Lambert/Pfizer, British

23 Biotechnology/Schering Plough and BMS, and are

24 listed below." Do you see that?

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1 A. Yes.

2 Q. At the time that this research funding
3 agreement was executed in March of 2001, British
4 Biotechnology, they weren't developing an MMPI any
5 longer, were they?

6 MR. WEINBERGER: Object to the form of the
7 question.

8 BY THE WITNESS:

9 A. Go back and look to see exactly -- which
10 time frame are we talking about now?

11 BY MR. DAVIS:

12 Q. This is signed -- this agreement was
13 signed on March 13, 2001. And I will direct your
14 attention, but I think we already saw in that, it
15 is Exhibit 37. You will see that's the February
16 2001 report regarding ABT-518, and that one
17 indicates that marimastat development was
18 discontinued on February 15th, 2001, right?

19 A. Yes, again, I have a vague memory of
20 this, I could be wrong, you'd have to check, but my
21 memory of this is, I think, that they stopped, and
22 they did stop, as you said, and they restarted it
23 later on, but, yes, at this time I think they had
24 stopped.

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1 Q. "At this time," you mean March of 2001?

2 A. Yes.

3 Q. So you would agree with me, at least,

4 that statement is incorrect, the statement that

5 British Biotechnology/Schering Plough had a

6 compound, an MMPI compound, in advance clinical

7 development for the treatment of cancer, was

8 incorrect as of March 13, 2001?

9 MR. WEINBERGER: Object to the form of the

10 question.

11 BY THE WITNESS:

12 A. Yes, it is factually incorrect. I think

13 what was trying to be explained here was that there

14 were compounds that had been in man extensively in

15 advanced clinical, but you are right, factually,

16 that's incorrect.

17 BY MR. DAVIS:

18 Q. If you look also at the page that ends

19 in 8121. We looked at this one before. This is

20 the annual development plan for Abbott 594, 8121.

21 A. I got it.

22 Q. And you would agree with me, Dr. Leiden,

23 that the statement on this page, that Abbott's

24 projected spending for ABT-594 for 2001 was 35

1 million, that that was wrong as of March 2001?

2 MR. WEINBERGER: Object to the form of the

3 question.

4 BY THE WITNESS:

5 A. No, what I would say is it disagrees

6 with the plan numbers that you had showed me

7 before.

8 BY MR. DAVIS:

9 Q. So --

10 A. It is really all based upon that

11 comparison.

12 Q. If these are supposed to be Abbott's

13 plan numbers, you would disagree with me that

14 35 million is wrong?

15 A. You are saying "if." I don't know what

16 these are, whether these are Abbott numbers. But

17 this number, 35 million, disagrees with the numbers

18 that you showed me from the Abbott plan, yes.

19 Q. Certainly, you would agree with me that

20 based on the documents we saw, Abbott's planned

21 spending for ABT-594 in 2001, was not 35 million?

22 A. Yes.

23 Q. It was substantially less than

24 35 million, correct?

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1 back here mark exhibit.

2 (WHEREUPON, said document was marked

3 Leiden Deposition Exhibit No. 40,

4 for identification, as of 4/26/07.)

5 BY MR. DAVIS:

6 Q. Dr. Leiden, you have what has been

7 marked as Exhibit 40, which is labeled an MMPI

8 monthly meeting agenda. Do you see that?

9 A. Yes, yes.

10 Q. You recognize MMPI as a reference to

11 ABT-518?

12 A. Yes. There could have been other

13 compounds, as well, but 518 was one of them.

14 Q. Did Abbott have other MMPI compounds

15 under development as opposed to in discovery --

16 A. No.

17 Q. -- as of April 2001?

18 A. No.

19 Q. The second page of this document you see

20 there is some handwritten notes, about midway down

21 the page. It says, "Post meeting strategy:

22 Perry's plan to kill if Leiden says no go. Jeff

23 wants to kill this. ASCO results neutral, negative

24 not positive." Do you see that?

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1 A. Yes.

2 Q. Does that accurately reflect your view

3 at the time, that you intended to kill the

4 development of ABT-518 as of April 2001 if the

5 results from the ASCO conference were neutral or

6 negative?

7 A. I don't know what's meant by neutral or

8 negative, so let me give you accurately what I

9 wanted to do, which is actually partly put on the

10 first page where it says, "Leiden wants to make

11 go/no go decision based on competitor data at

12 ASCO."

13 So what that meant was we knew that at

14 ASCO we would see detailed clinical data from a

15 number of other compounds in this class. And we

16 knew that if there was evidence of severe side

17 effects, particularly joint side effects as a class

18 effect, that that was going to make it difficult,

19 if not impossible, to develop this compound.

20 And in addition, we were very interested

21 in understanding the detailed efficacy data,

22 because based upon that data if there was only

23 modest efficacy, for example, and severe class

24 effect joint pain, we felt that then our premise

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1 that we could develop a more potent selective
2 compound to get around that would be unlikely to be
3 true.

4 That's what my point of view was about
5 the ASCO data, and this is an accurate statement on
6 the first page that we wanted to make the decision
7 based on that competitive data. Because the
8 advantage of that, of course, was that we were
9 doing it on their dime. In other words, the
10 competitors were paying for these advanced stage
11 clinical studies on hundreds of patients, so we
12 were going to see how the compounds behaved in
13 hundreds of patients in a very short period of time
14 with no additional money from us.

15 Q. The portion of the document you referred
16 to was the one on Page 1 next to "kill scenario"?

17 A. Yes.

18 Q. Looking back again at Page 2, is it fair
19 to say that -- I am trying to incorporate what you
20 just testified to -- is that if you regarded the
21 data from ASCO in May of 2001 as inconclusive with
22 respect to MMPIs, that it was your plan or
23 expectation that further development of ABT-518
24 would be halted?

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1 program was minor, and most drugs, by the way,
2 don't have IV forms.

3 Q. When did Abbott decide to finally fund a
4 program for ABT-773?

5 A. I just don't remember that. I have this
6 vague memory we looked at a timeline at one point
7 that said we can finish the Phase III trials and
8 then provide the funding for IV form and still get
9 there on time, but I just don't remember what
10 happened with that.

11 MR. DAVIS: Let's mark this please as the next
12 exhibit.

13 (WHEREUPON, said document was marked
14 Leiden Deposition Exhibit No. 45,
15 for identification, as of 4/26/07.)

16 BY MR. DAVIS:

17 Q. Dr. Leiden, you have Exhibit 45 in front
18 of you. Have you seen -- first, let me ask you,
19 have you seen this document before?

20 A. This one, I don't remember seeing.

21 Q. Do you recognize the logo on the first
22 page, the very cover page of the document?

23 A. No.

24 Q. "AIV," does that have any meaning to

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1 you?

2 A. It doesn't, sorry. But as I said, there

3 were a lot of acronyms at Abbott.

4 Q. Do you recall receiving a presentation,

5 or being present at a presentation on a 773 update

6 in February of 2001?

7 A. I don't recall it. That doesn't mean I

8 wasn't there. I just don't recall being there.

9 Q. Who was in charge of the 773 program as

10 of early 2001?

11 A. I believe it was Stan Bukofzer, but I

12 don't remember the time.

13 Q. Would you take a quick look at the page

14 that ends in 5069.

15 A. Yes.

16 Q. You see that there is a slide there

17 titled "Dosing Issue"?

18 A. Yes.

19 Q. "150 microgram BID versus 150 microgram

20 QD background," do you see that?

21 A. Yes.

22 Q. Now, is it correct "BID" references

23 twice a day, correct?

24 A. Correct.

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1 Q. And "QD" references once a day?

2 A. Correct.

3 Q. The first bullet point says, "Phase II

4 data indicated 300 milligram --" sorry, "300

5 micrograms"?

6 A. Milligram, that is milligram.

7 Q. Okay. "-- 300 milligram QD was not

8 viable due to high levels of diarrhea and taste

9 perversion." Is that accurate?

10 A. I haven't reviewed that data, but what

11 I do remember is that we decided to try 150 QD and

12 150 BID as opposed to 300 QD, and I believe it was

13 for GI tolerability issues, but I haven't seen that

14 data. I believe it is true.

15 Q. You recall discussions within Abbott

16 that the once a day versus twice a day dosing issue

17 was a -- had a potentially significant effect on

18 the commercial value of 773?

19 MR. WEINBERGER: Any time, this time?

20 MR. DAVIS: At any point in time.

21 MR. WEINBERGER: Any time.

22 BY THE WITNESS:

23 A. For certain indications, once a day

24 versus twice a day has commercial implications,

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1 particularly the more mild indications like
2 pharyngitis or AECB. It is less important by the
3 way for sinusitis and CAP, where there is a lot of
4 BID and TID drugs.

5 BY MR. DAVIS:

6 Q. You were aware of those potential
7 commercial implications before March of 2001, is
8 that right?

9 A. Yes, I think pretty much everybody who
10 has any knowledge of the field was aware of them.
11 Those weren't specific to this compound. They are
12 antibiotic commercial issues, in general.

13 (WHEREUPON, said document was marked
14 Leiden Deposition Exhibit No. 46,
15 for identification, as of 4/26/07.)

16 BY MR. DAVIS:

17 Q. You have what's been marked as
18 Exhibit 46 to your deposition.

19 A. Yes.

20 Q. You recall you had that portfolio review
21 in March of 2001 and one of the compounds that
22 presented at that review was ABT-773, correct?

23 A. Yes. All the other compounds were
24 presented there, so.

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1 Q. Was every compound in your portfolio --

2 A. I believe every compound -- there could
3 have been a few tiny ones that slipped by, but our
4 intent was to present every compound there, so
5 there must have been 100 compounds or more.

6 Q. Would look please at the page that ends
7 in the Bates 3212. I think it is a tenth page of
8 the presentation. You see there is a reference
9 there to "ABT-773 potential
10 issues/threats/negatives." Do you see that?

11 A. Yes.

12 Q. And one key issue is "Potential for
13 class labeling regarding QT prolongation effects."
14 Do you see that?

15 A. Yes, I do.

16 Q. You regarded that as a key issue at that
17 time?

18 A. Class labeling means that a drug is
19 labeled not because it has negative data, but
20 because the entire class has -- is labeled that way
21 regardless -- because it hasn't collected its own
22 data to show that. So what this really means is
23 that if we don't present evidence to the contrary,
24 showing that our drug doesn't have QT issues, there

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1 is a risk that we will get class labeled with

2 macrolides, a different class, because we were

3 labeled to have QT issues.

4 So what it really means to reflect is we

5 need to do the studies to show we don't have QT

6 issues. In fact, as I said we were already well

7 underway with those studies and they looked quite

8 good.

9 Q. Actually, I think my question was

10 simpler. You regarded that as a key issue at that

11 point in time, correct?

12 A. When you say "that," I wanted to explain

13 what I regarded as a key issue, so that was my

14 answer.

15 Q. So the potential for class labeling

16 regarding QT prolongation effects, you regarded

17 that as a key issue as of early March 2001, with

18 respect to 773, is that correct?

19 A. I regarded it as a potential issue that

20 we had already begun to address and were confident

21 we could address because it says potential issues,

22 not key issues up top.

23 Q. Directly above "Potential for class

24 labeling regarding QT prolongation effects," it

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1 says, "Key issue," correct?

2 A. Yes, but what I am telling you is that

3 my interpretation of this slide is that it presents

4 potential issues, and we had plans to -- we viewed

5 this as a potential issue that we were addressing

6 and planned to continue to address, and we felt

7 confident about the results we had already seen.

8 Q. Another item listed under Key Issues is

9 "IV formulation," correct?

10 A. Yes.

11 Q. And it says, "Need IV formulation to

12 strengthen strategic commercial and technical value

13 of the product", correct?

14 A. Yes.

15 Q. That's what the team working on ABT-773

16 was telling you at that point in time, correct?

17 A. This was the combined team from the

18 hospital products division and the pharmaceutical

19 products division. As I explained, this was much

20 more important to the hospital products division

21 than the pharmaceutical products division.

22 Q. That's what the team who was working on

23 this said?

24 A. Yes, but I am just explaining when you

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1 say "the team," the team was composed of people
2 from the hospital products division and the
3 pharmaceutical products division, and I am adding
4 the color that this was much more important to the
5 hospital products division than the pharmaceutical
6 products division.

7 Q. And then the next item under Key Issue
8 is "QD," which is once a day, "versus BID," twice a
9 day, "dosing impact on U.S. and ex-U.S. markets."
10 Do you see that?

11 A. Yes.

12 Q. You agree that that was a key issue at
13 that point in time?

14 A. In one or two indications, yes.
15 Pharyngitis and to some -- to a lesser extent,
16 acute exacerbation of chronic bronchitis, and as
17 they point out here, in the U.S.

18 Interestingly, outside the U.S., for a
19 variety of reasons, actually BID is preferred, as
20 it is in Japan.

21 Q. Did you agree at the time that it had
22 posed a significant commercial hurdle in the U.S.
23 as it is listed here?

24 A. In the two indications we talked about,

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1 acute pharyngitis and to a lesser extent acute
2 exacerbation of chronic bronchitis, BID dosing
3 really would present a significant commercial
4 hurdle.

5 MR. DAVIS: Let's mark this please as the next
6 exhibit.

7 (WHEREUPON, said document was marked
8 Leiden Deposition Exhibit No. 47,
9 for identification, as of 4/26/07.)

10 BY MR. DAVIS:

11 Q. Dr. Leiden, you have Exhibit 47 in front
12 of you, which appears to be a monthly highlights
13 report to you from Dr. Leonard dated November 9th,
14 2001. Do you see that?

15 A. Yes, I do.

16 Q. Do you see the references there to
17 ABT-773?

18 A. Yes.

19 Q. It says, "The Phase I QT study, MO1-325,
20 was put on hold at the second dosing period to
21 allow for the analysis of liver elevations seen in
22 four subjects. Analysis is ongoing and a
23 discussion with the FDA is planned for the first
24 week of November to discuss modifications to the

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1 additional trial to get approval.

2 When you factored all that in, the time,
3 the cost, the label that we were going to get, and
4 the indications, really, the drug was not
5 commercially viable, anymore. At least for us, for
6 a company the size of Abbott.

7 Q. Your memo of -- this says it is the
8 summary of the December 10th, 2001 meeting. When
9 did you send this memo?

10 A. I can't tell you that. It was likely
11 soon after the meeting, within a couple of weeks.

12 Q. One of the people you sent it to was
13 J. Leonard. That's Dr. Leonard?

14 A. Yes.

15 MR. DAVIS: Mark this please as the next
16 exhibit.

17 (WHEREUPON, said document was marked

18 Leiden Deposition Exhibit No. 48.

19 For identification, as of 4/26/07.)

20 BY MR. DAVIS:

21 Q. Dr. Leiden, I think, you referenced
22 earlier in your testimony today a memo, a letter
23 that you sent to, ultimately, to Mr. White, Miles
24 White, explaining the basis for the recommendation

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1 that Abbott cease development of ABT-773.

2 A. Yes.

3 Q. Is this a copy of that letter or that

4 memo?

5 A. Yes.

6 Q. You don't have to go through it in

7 detail. I think you have already addressed some of

8 this, but did you attempt, in putting this memo

9 together for Mr. White, to accurately explain to

10 him the basis for the recommendation?

11 A. Yes.

12 Q. Is the information contained in this

13 document, to the best of your knowledge, truthful

14 and accurate as of the time it was sent to

15 Mr. White in early January of 2002?

16 MR. WEINBERGER: Check, because you are being

17 asked to verify everything in here, just make sure

18 you have time to look at it.

19 BY THE WITNESS:

20 A. Maybe I ought to read it. I am assuming

21 it is the final memo.

22 MR. DAVIS: The question is whether this is

23 actually the memo that he sent.

24 MR. WEINBERGER: No, you are just asking him

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1 accurate and timely way is important from a
2 shareholder point of view. So we always, on major
3 issues, had a carefully planned phased
4 communication plan. I am sure we did here, as
5 well, where we contacted partners, employees,
6 shareholders, et cetera.

7 MR. DAVIS: Mark that is the next exhibit.

8 MR. WEINBERGER: We did ask for a break.

9 MR. DAVIS: Let me finish this line of
10 questioning and then we can take a break.

11 (WHEREUPON, said document was marked

12 Leiden Deposition Exhibit No. 52,

13 for identification, as of 4/26/07.)

14 BY MR. DAVIS:

15 Q. Dr. Leiden, that is an e-mail from, I
16 think it is, Dr. Bukofzer to you?

17 A. Yes.

18 Q. Dated February 9th, 2002, attaching a
19 proposed Abbott 773 communications plan head count
20 reallocation assessment, do you see that?

21 A. Yes.

22 Q. Now, when did Abbott decide that it
23 needed to undertake a headcount reallocation with
24 respect to 773?

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1 A. I don't remember the time, but, again, I
2 want to emphasize that I think what you are seeing
3 here is a set of contingency planning that's based
4 upon the following sorts of considerations: When a
5 company like Abbott pulls the trigger on a
6 cancellation of a program, or on a major -- other
7 major event, we can't do that on a Thursday and
8 start planning for it on Thursday or Wednesday.

9 We typically plan weeks to months in
10 advance so we have everything buttoned down from
11 the standpoint of communication, jobs, spend, et
12 cetera. And so I think what you are showing me
13 here is a series of documents that talk about how
14 we are going to do that in the February time frame.
15 That's what's going on.

16 Q. Did Abbott actually begin to reallocate
17 employees on 773 before the decision was made to
18 stop development?

19 A. I don't know, but it is very possible,
20 because what happens is in an advanced program like
21 this, there is a very complex what's called a
22 Phase IIb/IV program that's planned and put into
23 place for the year, which assuming a positive
24 outcome in the Phase III studies, has to get

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1 started right away.

2 And so the way these programs are

3 planned, you say, "Okay. If we are going to plan

4 for success, we are going to have a positive

5 Phase III program. That's going to lead into the

6 following Phase IV program."

7 So you can see the huge dollar amounts

8 that are associated here. I think it was a \$70

9 million budget, which was the continuation of the

10 entire program as it rolls forward to filing and

11 launch.

12 So I think after we made this

13 recommendation, we began -- we had a lot of jobs

14 and people in place here. We began to look at this

15 and say, "Okay, if we do go forward, what's the

16 plan for the jobs. What's the plan for the

17 communication. What's the plan for the spend,"

18 because it is a very complex thing to shut down a

19 program with hundreds of people working on it

20 around the world, so that's what you are seeing

21 here.

22 Q. If you look at Page 3 of Exhibit 52, you

23 see there is actually a timeline here for

24 communication, correct?

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1 is how we would do it.

2 As I said, we would talk with our
3 partners about our plans for doing this. That
4 doesn't mean -- to be clear on that, it doesn't
5 mean that the final decision had been made.

6 It means we were putting in place all of
7 the communication, employee and contingency plans
8 so we could pull the trigger and do it in an
9 orthodox way. I believe we, again, I could be
10 wrong, but I believe we pulled the trigger more in
11 the May time frame, if I remember correctly.

12 MR. DAVIS: Take a break down.

13 THE VIDEOGRAPHER: Off the video record at
14 4:07 p.m. This concludes Tape No. 5.

15 (WHEREUPON, a recess was had.)

16 THE VIDEOGRAPHER: Back on the video record at
17 4:18 p.m. This is the beginning of Tape No. 6.

18 BY MR. DAVIS:

19 Q. Dr. Leiden, Exhibit 48 is your memo to
20 Mr. White containing the recommendation of the PEC
21 that development of ABT-773 be ceased?

22 A. Yes.

23 Q. Was it Mr. White's decision to cease
24 development of ABT-773?

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1 A. No, it was a decision of the senior
2 management group, including myself and Mr. White.
3 But as I said, this is a -- this was a significant
4 event for Abbott. I believe at the time it was the
5 only Phase III -- one of the only Phase III
6 projects still in development.

7 And so, for significant decisions like
8 that, of course, I both inform, consult with and
9 discuss with Mr. White. And, like I told you, for
10 the pharmaceutical product groups, we had a
11 collaborative forum where we reach consensus on
12 decisions about -- after discussing, and we reached
13 consensus on this decision after discussing.

14 Q. Did you discuss the decision or the
15 recommendation concerning the proposed termination
16 and development of ABT-773 with Mr. White?

17 A. Yes.

18 Q. What did he have to say on the topic?

19 A. I think he had -- you don't know
20 Mr. White. So Mr. White is a -- he is a brilliant
21 guy, who asks lots of questions to inform and
22 educate himself. He is not a physician himself,
23 but he talked with me, with John Leonard, I believe
24 at the same meeting, and asked lots of very

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1 specific questions. I think saw a lot of the data.

2 Wanted to understand what the potential value of

3 the product that was still left was and what had

4 changed after the Phase III data.

5 And we went through all of that with

6 him, including, really, what's summarized in this

7 memo. And at the end of that, I think he agreed

8 that for certainly a company the size of Abbott,

9 the value of 773 had been decreased to the point

10 where it was no longer worth investing more money

11 in it. And that was particularly true because we

12 were able to share with him the comments from the

13 Ketek advisory committee and the FDA's change in

14 stance that indicated that not only had the product

15 profile changed, but the FDA's bar had changed and

16 we were going to need to invest a lot more money.

17 Just so you understand, this was a

18 difficult decision. We, Abbott, had invested, I

19 think, a couple hundred million dollars in this

20 drug. It was the only Phase III drug in our

21 pipeline. And so to announce that we were stopping

22 development of this drug was not an easy decision

23 for any of us, but it was the right decision.

24 You know, that's really borne out by the

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1 fact that if you look at what happened to Ketek,
2 Ketek has been remarkably unsuccessful. They have
3 lost hundreds of millions of dollars on that drug
4 since its launch. So it was the right decision,
5 but a hard one. I think he came to it the same way
6 we did.

7 Q. What else did Mr. White say to you on
8 the topic, as best you can recall?

9 A. He wanted to make sure we had a plan in
10 place for doing this. In other words, one of his
11 concerns is always employees, so he wanted to make
12 sure "What does it mean for employees?" He wanted
13 to understand that we had a communication plan in
14 place. He wanted to make sure we had discussed
15 things with partners. He went through the list of
16 things that he had to, all the boxes that have to
17 be checked when you are making an important
18 decision, and he sent us out, I believe, to do more
19 of that work, which is part of what you saw here.

20 Q. Where did the meeting with Mr. White
21 take place that you were recounting?

22 A. I believe it was in his office, but it
23 could have been in mine.

24 Q. How long after you sent the January 7th

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1 memo did that meeting take place?

2 A. It was within weeks, but I can't tell

3 you exactly when.

4 Q. Was it sometime in January of '02?

5 A. Either January or early February, I

6 believe, but you would have to check the schedules

7 to get that exactly. I just can't remember from

8 six years or five years ago what the exact dates

9 were.

10 Q. Did you have further meeting with

11 Mr. White on the topic?

12 A. I may have filled him in again on plans,

13 so my memory of this, which is pretty vague, is he

14 sent out and said, "Okay. I want to be sure you

15 have a communication plan, an employee plan," all

16 of these things. And we had started working on

17 that, but we didn't have one at that point.

18 I think I may have been then by myself,

19 without John, come back and reviewed some of that

20 with him at some point maybe in March or April.

21 Q. Is it fair to say Mr. White gave

22 responsibilities to people to go out and do the

23 things necessary to implement the recommendation?

24 A. I don't remember whether we -- what you

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1 are really asking me is, did we make the decision

2 during that meeting, and I don't remember that.

3 Q. My question is actually different. At

4 the meeting, did Mr. -- you said Mr. White said go

5 out and do -- make sure you have a communications

6 plan and all those things?

7 A. Yes.

8 Q. Your recollection is that Mr. White was

9 in concurrence that the analysis that you and the

10 PEC had performed was the correct analysis?

11 A. I think he accepted this analysis, but,

12 again, I want to be careful in answering your

13 question.

14 My memory of the meeting was we didn't

15 make a final decision at the meeting. What he said

16 was, "I see this." I believe he asked a lot of

17 questions. "I want to think about it more, but in

18 the meantime, go out and make sure that you put all

19 this together, because it is going to take some

20 time, so when we do make the decision, we are ready

21 to pull the trigger in an organized manner."

22 That's my memory of the meeting and we did that.

23 Q. When was the meeting held, or when was

24 the formal decision made?

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1 A. Again, my memory of this is it was made
2 in the May time frame.

3 Q. And --

4 A. Decision to pull the trigger.

5 Q. At what event?

6 A. I don't remember that, whether there was
7 a formal meeting, whether he and I talked, I just
8 don't remember how -- what the event was.

9 Q. And how was that -- how was that
10 decision memorialized within Abbott?

11 A. There was a public announcement, for one
12 thing, very soon thereafter, because we have an
13 obligation to our shareholders, et cetera. Very
14 soon after the decision, we made a public
15 statement. I believe I may have made -- we made
16 it -- either had an analyst call, or we already had
17 a quarterly call scheduled, so we talked about it
18 very soon thereafter on the analyst call, I think,
19 and that was a public disclosure of it, as well.

20 But, again, the exact details of this
21 are -- I just don't remember the timeliness,
22 because I don't have access to the schedules and
23 things.

24 Q. Was John Hancock notified separately of

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1 Abbott's decision to cease development of ABT-773?

2 A. I believe so. Again, I would point you
3 to that memo, which you showed me, that says we
4 were clearly aware that they needed to be, and --
5 let me just find that. That's the e-mail that says
6 "To Stan," Exhibit 51, "773 is a Hancock project.
7 We will need to notify them shortly if the decision
8 is to shut down," or his e-mail to me.

9 I believe, we were aware of it and I do
10 believe we notified Hancock, but I didn't notify
11 Hancock because that was all done through Jim
12 Tyree's office.

13 Q. Did Mr. Tyree attend that meeting with
14 Mr. White shortly after he received the January 7
15 memo?

16 A. I don't believe so. That's not my
17 memory. I think that was me and John Leonard.

18 MR. DAVIS: Would you mark this as the next
19 exhibit.

20 (WHEREUPON, said document was marked
21 Leiden Deposition Exhibit No. 53,
22 for identification, as of 4/26/07.)

23 BY MR. DAVIS:

24 Q. Dr. Leiden, you have in front of you

Leiden, Jeffrey [Linked] 04/26/2007 8:30:00 AM

1 Exhibit 53. Have you seen this document before?

2 A. Let me just make sure. I think I saw it

3 yesterday. Yes, yes, I saw it yesterday.

4 Q. Had you seen it before then?

5 A. I am sure I did, because it is an e-mail

6 to and from me, but I don't recall writing the

7 e-mail at this time. Again, it was five years ago.

8 Q. I believe that the sequence of e-mails,

9 and the first one listed here is one from

10 Dr. Leonard to you from April 15th of 2002, early

11 in morning, 7:55 a.m.

12 It says, "Two quickies:" Moving to the

13 second paragraph, it says, "Second and more

14 important, we own --" that may be "we owe Hancock"

15 maybe, but "we own Hancock. How do you want to

16 handle the 773 communication? We could say that we

17 are analyzing data and have slowed down (as we have

18 been saying externally), but if the questioning

19 goes deeper, we will need a plan as the status will

20 evolve quickly." Do you see that?

21 A. Yes.

22 Q. At this point in time, had Abbott made

23 the decision to cease the development of 773?

24 A. Again, my memory is we made the decision

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1 in May. This is in April, so according to that

2 memory, I would say no.

3 Q. Well, as of April of 2002, was Abbott

4 telling -- saying one thing externally about its

5 plans for 773, but telling people internally

6 something different?

7 A. No, I don't think that's what it says.

8 I think this says what we were saying externally,

9 because we hadn't made the decision, is that we had

10 slowed down, which was true, but had not made a

11 decision.

12 Then you can see in my e-mail to him, I

13 give him very specific instructions about what we

14 should tell Hancock, which I believe reflected what

15 was going on. We were reviewing the Ketek

16 situation in terms of the safety database, we were

17 caring out additional studies, I believe they were

18 still going on, and we were analyzing existing data

19 for its impact on label and market opportunity.

20 Those were the factors that eventually

21 went into the decision. That we expect the

22 analysis to be complete by June, July, and at that

23 point we will be in a position to make decision on

24 how to proceed. We will keep them in the loop.

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1 Q. You didn't tell Hancock -- you didn't

2 instruct Dr. Leonard to tell Hancock that a

3 recommendation had been made within Abbott to cease

4 development of ABT-773, did you?

5 A. No, I did not.

6 Q. Why not?

7 A. I --

8 Q. That was true at the time, correct?

9 A. Yes, but our -- I believe that our

10 obligation to Hancock was not to inform them as to

11 every internal discussion or meeting that took

12 place at Abbott, or every recommendation, but to

13 inform them when we came to a decision. That's how

14 we typically deal with our partners.

15 And having been on the other side of

16 that, the last thing I want to know from our

17 partners is every meeting or recommendation or

18 internal meeting they had. I want to know when

19 they make a decision and why.

20 By the way, there are public disclosure

21 issues there, as well, in terms of making

22 disclosures to Hancock, for instance, that wouldn't

23 be made publicly. So you have to be consistent in

24 your communications. That's what we were doing

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1 here, and I believe we were also being entirely

2 honest and reflective of what was going on.

3 Q. You understood as of April 2002 that you

4 owed Hancock an update on the status of 773, right?

5 A. I didn't, but this memo tells me that we

6 did, that that was communicated to me, yes.

7 Q. Are you aware under the terms of the

8 research funding agreement that Abbott must

9 periodically provide updates to John Hancock

10 regarding the status of the compounds?

11 A. I knew there were periodic updates, but

12 I wasn't aware of what the details were.

13 Q. You believe those updates had to be

14 truthful and accurate at the time they were

15 provided?

16 A. Yes.

17 Q. And if you were in Hancock's shoes, as

18 of April 2002, would you want to know that Abbott

19 had decided internally to -- had recommended

20 internally to cease the development of 773?

21 MR. WEINBERGER: I object to the form of the

22 question.

23 BY THE WITNESS:

24 A. Actually, it is an interesting question.

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1 If I were Hancock, frankly, it doesn't make a lot
2 of difference to me until a decision is made. And
3 frankly, it doesn't make a lot of difference to me
4 one way or another, because the revenues from these
5 drugs were a number of years out. There was no
6 financial impact directly at that time on Hancock,
7 as far as I know, of that recommendation. But more
8 importantly, there is no impact until a decision is
9 made.

10 And so if I were Hancock, I would want
11 to know when the decision was made and why the
12 decision was made, and I think we provided them
13 with that, I believe.

14 Q. So everything that you recommended be
15 told to John Hancock in this e-mail you think was
16 true as of that time?

17 A. Yes.

18 Q. And you believe that the decision to
19 actually terminate the development was made around
20 May of 2002?

21 A. That's my memory, yes. And then was
22 announced shortly thereafter, but I can tell you
23 whenever the announcement was made, the decision
24 was made very soon before, because we were very

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1 careful about announcing publicly once we had made
2 important decisions.

3 Q. Did you instruct Dr. Leonard to inform
4 Hancock when the decision was made?

5 A. I do not -- I wasn't involved in
6 informing Hancock, so I can't tell you how that was
7 done. I believe it was done, but I don't have
8 specific knowledge who or how it was done.

9 Q. Going back to McKinsey, the work
10 McKinsey did in the Knoll integration. Did
11 McKinsey provide any sort of report or study to
12 Abbott as a result of its work on that Knoll
13 integration project?

14 A. No, I don't believe so. I think mostly
15 what they provide -- what I remember that they
16 provided in terms of written documents was
17 templates for doing an integration, so they had a
18 whole group that had generated templates, for
19 example, that showed what the important steps of
20 the integration were, how to track an integration,
21 et cetera, et cetera. My memory is the written
22 documents they supplied were mostly templates.
23 Again, they didn't supply them to me. They would
24 have supplied them to Joe Nemmers.

12/04 2007 14:33 FAX 0031235544496

Abbott Medical

002

Errata Sheet

Page: 1 Of Total Pages:

I wish to make the following changes to my deposition/statement:

Page #: 9, Line #: 6
As appears in Transcript: Leidan
To: Leiden
Reason: Correct name of city

Page #: 16, Line #: 18
As appears in Transcript: leader
To: manager
Reason: this is the correct job title.

Page #: 36, Line #: 15
As appears in Transcript: Beijenen
To: Beijnen
Reason: is the correct name

Page #: 37, Line #: 17
As appears in Transcript: —
To: no others
Reason: missing from transcript

04 APR '07
DATE


DEPONENT'S SIGNATURE

12/04 2007 14:33 FAX 0031235544496

Abbott Medical

003

Errata Sheet

Page: 2 Of Total Pages:

I wish to make the following changes to my deposition/statement:

Page #: 41, Line #: 7

As appears in Transcript: tries to

To: nothing → leave out of text

Reason: 'tries to' is wrong, this will actually be done

Page #: 41, Line #: 11

As appears in Transcript: I do not know

To: Abbott, datamanagement.

Reason: because this is what is was

Page #: 62, Line #: 2

As appears in Transcript: To

To: leave out, start sentence with "As soon as..."

Reason: otherwise sentence is not well understood

Page #: 65, Line #: 6-7

As appears in Transcript: from which --

To: yet

Reason: better reflects content of answer

4/4/07
DATE

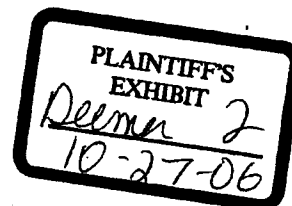

DEPONENT'S SIGNATURE

DEPONENT'S SIGNATURE

Deposition Exhibit 1

P's Exhibit 32

Part 1



RESEARCH FUNDING AGREEMENT

by and between

ABBOTT LABORATORIES

and

JOHN HANCOCK LIFE INSURANCE COMPANY,

JOHN HANCOCK VARIABLE LIFE INSURANCE COMPANY,

and

INVESTORS PARTNER LIFE INSURANCE COMPANY

dated as of

March 13, 2001

Leiden EXHIBIT 1
FOR I.D. 4-26-07 JAC

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JH 008076

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6.	Miscellaneous Choate, Hall & Stewart memoranda to John Hancock regarding "outstanding issues"
7.	Miscellaneous correspondence between Choate, Hall & Stewart and Abbott Laboratories
8.	Copies of Choate, Hall & Stewart legal bills
9.	Working Group List

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JH 008077

RESEARCH FUNDING AGREEMENT

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dated as of

March 13, 2001

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JH 008080

RESEARCH FUNDING AGREEMENT

This Research Funding Agreement is made as of March 13, 2001, by and between Abbott Laboratories; an Illinois corporation ("Abbott"), with its principal offices at 100 Abbott Park Road, Abbott Park, Illinois 60064-6049, and John Hancock Life Insurance Company, a Massachusetts corporation, John Hancock Variable Life Insurance Company, a Massachusetts corporation, and Investors Partner Life Insurance Company, a Delaware corporation (collectively, "John Hancock"), each with its principal offices at 200 Clarendon Street, Boston, Massachusetts 02117.

WITNESSETH

WHEREAS, Abbott is a global healthcare company actively engaged in the research and development of human pharmaceutical products;

WHEREAS, Abbott is interested in obtaining additional funding to support such research and development activities with respect to certain pharmaceutical products which are under development; and

WHEREAS, John Hancock is interested in providing such additional funding in exchange for the right to receive future milestone and royalty payments from Abbott.

NOW, THEREFORE, in consideration of the foregoing and the mutual covenants and undertakings contained herein, the parties hereto agree as follows:

ARTICLE I DEFINITIONS

In addition to the other terms defined elsewhere herein, the following terms shall have the following meanings when used in this Agreement (and any term defined in the singular shall have the same meaning when used in the plural and vice versa, unless stated otherwise):

1.1 "Affiliate" shall mean, with respect to each party, any corporation or other form of business organization, which directly or indirectly owns, controls, is controlled by, or is under common control with, such party. An entity shall be regarded as being in control of another entity if the former entity has the direct or indirect power to order or cause the direction of the policies of the other entity whether (i) through the ownership of more than fifty percent (50%) in the United States, or thirty percent (30%) or more outside the United States, of the outstanding voting securities (or other ownership interest for a business organization other than a corporation) of that entity; or (ii) by contract, statute, regulation or otherwise.

1.2 "Aggregate Carryover Amount" shall have the meaning given in Section 3.3.

-2-

1.3 "Aggregate Spending Target" shall mean Six Hundred Fourteen Million Dollars (\$614,000,000).

1.4 "Annual Carryover Amount" shall have the meaning given in Section 3.3.

1.5 "Annual Minimum Spending Target" for each Program Year, shall mean the sum of (i) the Program Payment of John Hancock for such Program Year as specified in Section 3.1, (ii) Fifty Million Dollars (\$50,000,000), and (iii) any Annual Carryover Amount for the prior Program Year pursuant to Section 3.3. With respect to the fifth Program Year, the "Annual Minimum Spending Target" shall mean the Annual Carryover Amount for the prior Program Year pursuant to Section 3.3.

1.6 "Annual Research Plan" shall mean, for the Program Years in the Program Term, a reasonably and consistently detailed statement of the objectives, activities, timetable and budget for the Research Program for every Program Year remaining in the Program Term, it being understood that less detail shall be required for Program Years that are not the current Program Year. The first Annual Research Plan is attached as Exhibit 1.6. "Annual Research Plan" shall mean, for those years occurring after the expiration of the Program Term, a reasonably and consistently detailed statement of the objectives, activities, timetable and budget for the Research Program for such year only.

1.7 "Bundled Product" shall have the meaning given in paragraph (b) of the definition of Net Sales.

1.8 "Ceased Program" shall mean at least one year has elapsed since Abbott ceased its directed efforts with respect to the applicable Preclinical Program (FTI Program, ED Program or MMPI Program), meaning that Abbott has eliminated the funding for the established research program identified by a core group of researchers dedicated to the applicable Preclinical Program. The continued existence of a researcher separate and apart from such core group shall not affect the determination that a Preclinical Program has ceased.

1.9 "Combination Product" shall mean any product containing one or more Program Compounds combined as a single pharmaceutical product with one or more other therapeutically active ingredients.

1.10 "Commercially Reasonable Efforts" shall mean efforts which are consistent with those normally used by other pharmaceutical companies with respect to other pharmaceutical compounds or products which are of comparable potential commercial value and market potential at a similar stage of development or product life, taking into account, without limitation, issues of safety and efficacy, compound or product profile, proprietary status, the regulatory environment and the status of the compound or product and other relevant scientific factors.

1.11 "Compound Reports" shall have the meaning given in Section 12.2(i).

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1.12 "Confidential Information" shall have the meaning given in Section 10.2.

1.13 "Delivery System Product" shall have the meaning given in paragraph (d) of the definition of Net Sales.

1.14 "Dollars" or "\$" shall mean United States dollars.

1.15 "ED Program" shall mean all of Abbott's discovery efforts to identify compounds (including the identification of pre-clinical and development compounds owned by third parties) which modulate dopamine receptors for the purpose of treating erectile dysfunction.

1.16 "Eisai Agreement" shall mean the License Agreement dated June 29, 2000 between Eisai Co., Ltd. and Abbott related to the Program Compound known as ABT-751.

1.17 "Eisai Territory" shall mean the countries listed on Exhibit 1.17 hereto.

1.18 "Execution Date" shall mean the date set forth in the introductory paragraph to this Agreement.

1.19 [Intentionally Omitted.]

1.20 "FDA" shall mean the U.S. Food and Drug Administration or any successor entity thereto.

1.21 "First Commercial Sale" shall mean the first sale of a Product in a given country by Abbott, its Affiliates or Licensees to an unaffiliated third person after Regulatory Approval has been granted in such country.

1.22 "FTI Program" shall mean all of Abbott's discovery efforts to identify compounds (including the identification of pre-clinical and development compounds owned by third parties) which act as farnesyl transferase inhibitors for the purpose of treating cancer.

1.23 "In-License Agreements" shall mean the Eisai Agreement, the Wakunaga Agreement and the Taisho Agreement.

1.24 "International Territory" shall mean all areas of the world outside the U.S. Territory.

1.25 "Investigational New Drug Application" shall mean an investigational new drug application filed with the FDA in order to commence human clinical testing of a drug in the United States.

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1.26 "Licensee" shall mean any party licensed or otherwise authorized in writing by Abbott, its Affiliates or its licensees to market, distribute or sell Products and from whom Abbott receives a royalty or other payment based upon sales of Products by such party, its affiliates or its licensees (it being understood that a party that is a merely a distributor, wholesaler or similar reseller of Products is not a Licensee hereunder). In no case shall Eisai Co., Ltd. or Taisho Pharmaceutical Co., Ltd. be considered Licensees under the terms of the Eisai Agreement or Taisho Co-Development Agreement with respect to the Eisai Territory or Japan, respectively.

1.27 "Losses" shall mean any claims, demands, liabilities, costs, damages, judgments, settlements and other reasonable expenses (including attorneys' fees).

1.28 "Milestone Payment" shall have the meaning given in Section 6.3.

1.29 "MMPI Program" shall mean all of Abbott's discovery efforts to identify compounds (including the identification of pre-clinical and development compounds owned by third parties) that inhibit matrix metalloproteinase and treat cancer.

1.30 "NDA" shall mean a New Drug Application (as defined by the FDA) filed with the FDA for the purpose of obtaining Regulatory Approval of a Product in the U.S. Territory.

1.31 "Net Sales" shall mean:

- (a) the total gross sales of the Products (or, for purposes of clauses (b) and (c), the Bundled Products and Combination Products), in each case as set forth on the invoices for such sales by Abbott, its Affiliates and Licensees to unaffiliated third parties in any given period, plus, if applicable, the fair market value of all properties and services received in consideration of a sale of the Products (or, for purposes of clauses (b) and (c), the Bundled Products and Combination Products) by Abbott, its Affiliates and Licensees to unaffiliated third parties during such period, less the following deductions directly paid or actually incurred by Abbott, its Affiliates or Licensees during such period with respect to the sale of the Products (or, for purposes of clauses (b) and (c), the Bundled Products and Combination Products) to the extent included in the gross invoiced sales price therefor:
 - (i) discounts, credits, rebates, allowances, adjustments, rejections, recalls and returns;
 - (ii) price reductions or rebates, retroactive or otherwise, imposed by government authorities;
 - (iii) sales, excise, turnover, inventory, value-added and similar taxes assessed on the royalty-bearing sale of Products;

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- (iv) transportation, importation, insurance and other handling expenses directly chargeable to the royalty-bearing sale of Products;
 - (v) charge backs granted to unaffiliated drug wholesalers; and
 - (vi) the portion of management fees paid to unaffiliated group purchasing organizations that relate specifically to the royalty-bearing sale of Products.
- (b) With respect to a Product which is sold together with any other products and/or services in a country at a unit price, whether packaged together or separately (a "Bundled Product"), the Net Sales of such Bundled Product shall first be calculated in accordance with the definition of Net Sales under paragraph (a), and then the Net Sales of such Bundled Product shall be determined on a country-by-country basis as follows:
- (i) multiply the Net Sales of such Bundled Product in such country by the fraction $A/(A+B)$ where A is the average selling price of such Product in such country when sold separately and B is the total of the average selling prices in such country of each such other product(s) and/or service(s) in such Bundled Product when sold separately; or
 - (ii) if (x) either the average selling price of such Product or the total of the average selling prices of each such other products and/or services in such Bundled Product in such country is not available as of such date or (y) such Product is not sold separately in such country, multiply the Net Sales of such Bundled Product in such country by a percentage determined by the mutual agreement of the Parties which represents the proportionate economic value in such country of such Product relative to the economic value in such country contributed by the other products and/or services in such Bundled Product.
- (c) With respect to a Combination Product, the Net Sales of such Combination Product shall first be calculated in accordance with the definition of Net Sales under paragraph (a), and then the Net Sales of such Combination Product shall be determined on a country-by-country basis as follows:
- (i) multiply the Net Sales of such Combination Product in such country by the fraction $A/(A+B)$, where A is the total of the average selling prices of the Program Compounds in such

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Combination Product when sold separately in such country and B is the total of the average selling prices of each other therapeutically active ingredient when sold alone as a pharmaceutical product in such country; or

- (ii) if (x) either the average selling price of all Program Compounds in such Combination Product or the total of the average selling prices of each other therapeutically active ingredient in such Combination Product in such country is not available or (y) such Program Compounds are not sold separately in such country, multiply the Net Sales of such Combination Product by a percentage determined by mutual agreement of the Parties, which represents the proportionate economic value in such country of all Program Compounds in such Combination Product relative to the economic value in such country contributed by all other therapeutically active ingredients in such Combination Product.
- (d) For purposes of this paragraph (d), a "Premium Delivery System" means any delivery system comprising device(s), equipment, instrumentation or other non-ingestible components (but not solely containers or packaging) designed to assist in the administration of a Product, such as the Abbott ADD-Vantage® System. With respect to a Product which is sold together with a Premium Delivery System (a "Delivery System Product") in a country at a unit price, the Net Sales of such Delivery System Product shall first be calculated in accordance with the definition of Net Sales under paragraph (a), and then the Net Sales of such Product shall be determined on a country-by-country basis as follows:
- (i) if the Product is sold separately without the Premium Delivery System in a country, reduce the Net Sales of such Delivery System Product in such country by the amount that the average selling price of the Delivery System Product in such country exceeds the average selling price of such Product as sold separately in such country; or
 - (ii) if the Product is not sold separately without the Premium Delivery System in such country, reduce Net Sales of such Delivery System Product by an amount, determined by mutual agreement of the Parties, which represents the proportionate economic value in such country added by the Premium Delivery System.
- (e) Net Sales shall not include any sales of Products containing one Program Compound (and no other Program Compound) known as (i) ABT-751 by Eisai Co. Ltd., its affiliates or licensees in the Eisai Territory or (ii) ABT-

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773 by Taisho Pharmaceutical Co., Ltd., its affiliates or licensees in Japan. Notwithstanding the foregoing sentence, Net Sales shall include in all instances sales by such parties of such products that are outside such territories, respectively.

1.32 "Parties" shall mean Abbott and John Hancock.

1.33 "Patents" shall have the meaning set forth in Section 12.2(e).

1.34 "Phase I Clinical Trial" shall mean a clinical trial of a Program Compound which utilizes a limited number of human beings preliminarily to address safety and to determine what doses can be safely tolerated.

1.35 "Phase II Clinical Trial" shall mean a controlled clinical trial, the primary objective of which is to ascertain additional data regarding the safety and tolerance of one of the Program Compounds and preliminary data regarding such Program Compound's efficacy.

1.36 "Phase III Clinical Trial" shall mean one or a series of controlled pivotal studies of a specific Program Compound by administration of such Program Compound to human beings where the principal purpose of such trial is to provide confirmatory safety and efficacy data necessary to support the filing for Regulatory Approval of a Product.

1.37 "Preclinical Programs" shall mean the following preclinical and clinical programs with potential backup compounds in accordance with Section 4.3(a): the FTI Program, the ED Program and the MMPI Program.

1.38 "Premium Delivery System" shall have the meaning given in paragraph (d) of the definition of Net Sales.

1.39 "Product" shall mean any product containing one or more of the Program Compounds as an active ingredient, alone or in combination with other active ingredients (including any Bundled Product and any Combination Product).

1.40 "Program Compounds" shall mean (i) the compounds listed on Exhibit 1.40; (ii) the first compound (the selection of which shall be consistent with Abbott using Commercially Reasonable Efforts) from each of the Preclinical Programs to enter Phase I Clinical Trial; (iii) any compounds or products substituted or added by Section 4.3; (iv) all line extensions and formulations of the foregoing; and (v) all analogs, isomers, improvements, derivatives and modifications of the foregoing unless such analog, isomer, improvement, derivative or modification would be considered a new chemical entity and required by the FDA to reenter Phase I Clinical Trial. A compound or product shall be considered a Program Compound regardless of the indication for which it is used.

1.41 "Program Inventions" shall have the meaning given in Section 5.1.

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1.42 "Program Payments" shall have the meaning given in Section 3.1.

1.43 "Program Related Costs" shall mean (i) all direct and indirect costs and expenses that are incurred by Abbott on the Research Program during a given Program Year and allocated in a manner consistent with Abbott's internal, pharmaceutical products division-wide allocation procedures; and (ii) the milestone and license fees paid during a given Program Year or during any extension period of the Program Term by Abbott to (a) Eisai Co. Ltd. (not to exceed Eighteen Million Dollars (\$18,000,000) in the aggregate with respect to the Program Compound known as ABT-751 pursuant to the Eisai Agreement) and (b) Wakunaga Pharmaceutical Co., Ltd. (not to exceed Twenty Seven Million Five Hundred Thousand Dollars (\$27,500,000) in the aggregate with respect to the Program Compound known as ABT-492 pursuant to the Wakunaga Agreement). Any payments made by Abbott to John Hancock pursuant to Sections 6.2 and 6.3(a), (b), (c), (d) and (e) shall constitute Program Related Costs. Any payment made by Abbott to John Hancock pursuant to Section 6.3(f) shall not constitute Program Related Costs. Set forth on Exhibit 1.43 is an example of the calculation of Program Related Costs for a particular Program Compound.

1.44 "Program Term" shall mean a period of four (4) consecutive Program Years.

1.45 "Program Year" shall mean a period of twelve (12) consecutive calendar months commencing on January 1 of each year, except that the first Program Year shall commence on the Execution Date and end on December 31, 2001.

1.46 "Quarterly Reporting Period" shall mean the calendar quarter with respect to the U.S. Territory together with the fiscal quarter ending on the final day of February, May, August and November (as the case may be) with respect to the International Territory. For example, the Quarterly Reporting Period that comprises the second calendar quarter with respect to the U.S. Territory also includes the period from March 1 through May 31 with respect to the International Territory. If Abbott adopts the calendar year as its fiscal year for the International Territory, then the Quarterly Reporting Period for the International Territory shall also be the calendar quarter.

1.47 "Research Program" shall mean all of Abbott's, its Affiliates' and Subcontractors' activities directed towards obtaining Regulatory Approval for the Products, including research, development, safety and efficacy studies, clinical trials, process development, formulation work, regulatory, quality, data collection and analysis and project management.

1.48 "Regulatory Approval" shall mean: (i) with respect to the U.S. Territory, the receipt of approval from the FDA to market a Product in the U.S. Territory; and (ii) with respect to any country in the International Territory, receipt of the governmental approvals required to market a Product in such country, including any pricing and reimbursement authorization required in such country.

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1.49 "Replacement Compound" shall mean a compound (i) made available to Abbott as a result of any transaction involving Abbott or its Affiliates (whether by merger, acquisition or sale of assets or equity, or by license or otherwise), (ii) used for the same class of indications as the Ceased Compound (for example, anti-infectives, cancer, cardiovascular or pain), and (iii) having at least the current and projected potential commercial value to John Hancock as the Ceased Compound.

1.50 "Royalty Term" shall mean, with respect to each Product in each country, a period of ten (10) years from the later of (x) the date of First Commercial Sale of such Product in such country and (y) the two year anniversary of the Execution Date; provided that (i) the obligation to make royalty payments on the Product shall not begin until the two-year anniversary of the Execution Date (and only with respect to Net Sales occurring on or after such date) and (ii) Abbott's obligation to make royalty payments shall cease on December 31, 2015.

1.51 "Subcontractor" shall have the meaning given in Section 2.4.

1.52 "Taisho Agreement" shall mean the Co-Development Agreement dated September 30, 1997 between Taisho Pharmaceutical Co., Ltd. and Abbott related to the Program Compound known as ABT-773.

1.53 "Territory" shall mean both the U.S. Territory and the International Territory, excluding the Eisai Territory with respect to the Program Compound known as ABT-751.

1.54 "U.S. Territory" shall mean the United States of America, excluding Puerto Rico and the U.S. Virgin Islands.

1.55 "Wakunaga Agreement" shall mean the License Agreement dated December 1, 1999 between Wakunaga Pharmaceutical Co., Ltd. and Abbott related to the Program Compound known as ABT-492.

ARTICLE 2 ANNUAL RESEARCH PROGRAM

2.1 Research Program Term. The Research Program shall be conducted by Abbott during the Program Term, and beyond the Program Term until Abbott either abandons development in accordance with the terms hereof or receives Regulatory Approval for each Program Compound, or some combination thereof.

2.2 Research Plan. The Research Program shall be conducted by Abbott in each Program Year in accordance with the Annual Research Plan for such Program Year. The Annual Research Plan will be provided to John Hancock until Abbott either abandons development in accordance with the terms hereof, or receives Regulatory Approval for, each Program Compound in the U.S. Territory, or some combination thereof. The Annual Research Plan shall be prepared

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by Abbott and presented to John Hancock at least forty-five (45) days prior to the start of each Program Year. The first Annual Research Plan is attached as Exhibit 1.6. Abbott may modify the Annual Research Plan from time to time in order to best meet the objectives of the Research Program. Any such modifications to the Annual Research Plan shall be promptly provided to John Hancock. In addition, Abbott shall provide an Annual Research Plan for each year after the end of the Program Term as long as there is an active research program for any Program Compounds.

2.3 Conduct of Research. Abbott shall use Commercially Reasonable Efforts to conduct the Research Program in good scientific manner and using good laboratory practices, to achieve the objectives of the Research Program efficiently and expeditiously and to comply with all applicable laws and regulations. Notwithstanding anything in this Agreement to the contrary, Abbott does not represent, warrant or guarantee that the Research Program will be successful in whole or in part or result in the registration or commercialization of any pharmaceutical products or that any Products obtaining Regulatory Approval will be a commercial success.

2.4 Subcontracting Research. Abbott may subcontract or outsource to Affiliates or third persons (each, a "Subcontractor") any portion of the Annual Research Plan. Consistent with Abbott's past practices, each Subcontractor shall enter into a confidentiality agreement with Abbott and agreements pursuant to which such Subcontractor is required to comply with all applicable laws and regulations, including conducting the Research Program in good scientific manner and using good laboratory practices, with respect to its work on the Research Program. Abbott shall supervise and be responsible under this Agreement for the work of each such Subcontractor on the Research Program and no subcontracting or outsourcing shall relieve Abbott of any of its obligations hereunder.

2.5 Research Reports and Records. Abbott shall, no later than thirty (30) days before the last day of each Program Year, provide John Hancock with a reasonably detailed report setting forth the status of the Research Program and all Program Related Costs expended by Abbott during such Program Year. The Program Related Costs set forth in such report may include good faith estimates with respect to the last three (3) months of the Program Year, provided that the report under this Section 2.5 for the following Program Year contains the actual Program Related Costs for that three (3) month period. Such report shall also contain such other information related thereto as John Hancock may reasonably request from time to time. Abbott shall, and shall cause each Subcontractor to, maintain complete and accurate records, in sufficient detail and in good scientific manner appropriate for patent and regulatory purposes and for purposes of demonstrating compliance with the terms hereof, that fully and properly reflect all work done, results achieved and Program Related Costs expended in performance of the Research Program. The books and records of Abbott and each Subcontractor related to the Research Program, including, without limitation, those related to the expenditure of Program Related Costs, shall be subject to copying, inspection and audit by (and at the expense of) John Hancock at any time and from time to time. Such audit shall occur upon reasonable notice and during normal business hours by an independent auditor selected by John Hancock and reasonably acceptable to Abbott. John Hancock and its independent auditor shall maintain such

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records and information of Abbott in confidence in accordance with Article 10 and shall not use such records or information except to the extent permitted by this Agreement, including any enforcement of the provisions hereof. In the event that such audit reveals any material breach of Abbott's responsibilities hereunder, Abbott shall (i) pay the reasonable fees and expenses charged by such auditor, and (ii) fully and promptly cure such breach.

ARTICLE 3 RESEARCH FUNDING

3.1 John Hancock Program Payments. John Hancock shall make the following installment payments on the applicable payment date (the "Payment Date"), for the applicable Program Year, to Abbott to help support the Research Program (the "Program Payments"):

<u>Payment Date</u>	<u>Amount</u>	<u>Program Year</u>
December 1, 2001	\$50,000,000	First
December 1, 2002	\$54,000,000	Second
December 1, 2003	\$58,000,000	Third
December 1, 2004	\$52,000,000	Fourth

All Program Payments shall be expended by Abbott on Program Related Costs and for no other purpose. If John Hancock has not received at least thirty (30) days prior to the Payment Date both (i) the Annual Research Plan for such year and (ii) the report described in Section 2.5 for the previous Program Year, then John Hancock's obligation to make the Program Payment due on such Payment Date shall be suspended until thirty (30) days have elapsed from the date of John Hancock's receipt of both such Annual Research Plan and report.

3.2 Abbott Funding Obligation. Abbott shall spend on Program Related Costs: (i) during each Program Year, at least the Annual Minimum Spending Target for such Program Year and (ii) at least the Aggregate Spending Target during the Program Term. John Hancock's sole and exclusive remedies for Abbott's failure to fund the Research Program in accordance with this Section 3.2 (but not for any other breach of Abbott's other obligations hereunder) are set forth in Sections 3.3 and 3.4.

3.3 Carryover Provisions. Abbott shall be permitted to change its funding obligations under Section 3.2 only as follows:

- (a) If in any Program Year Abbott spends on Program Related Costs, the full amount of the Program Payment provided by John Hancock for such Program Year, but does not spend the full amount of the Annual Minimum Spending Target for such Program Year (including any Annual Carryover Amounts from any prior Program Years), Abbott will spend on Program Related Costs the difference between its expenditure on Program Related Costs for such Program Year and the Annual Minimum Spending Target

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for such Program Year (the "Annual Carryover Amount") in the subsequent Program Year. John Hancock's obligation to make any Program Payment for such subsequent Program Year, if any, pursuant to Section 3.1, shall be deferred until the time that Abbott has spent and notifies John Hancock that it has spent the Annual Carryover Amount in such subsequent Program Year; and

- (b) If Abbott does not expend on Program Related Costs the full amount of the Aggregate Spending Target during the Program Term, Abbott will expend the difference between its expenditures for Program Related Costs during the Program Term and the Aggregate Spending Target (the "Aggregate Carryover Amount") on Program Related Costs during the subsequent year commencing immediately after the end of the Program Term. If Abbott does not spend the Aggregate Carryover Amount on Program Related Costs during such subsequent year, Abbott will pay to John Hancock one-third of the Aggregate Carryover Amount that remains unspent by Abbott, within thirty (30) days after the end of such subsequent year.

3.4 Termination of John Hancock's Program Payment Obligation. If Abbott: (i) abandons development of all Preclinical Programs and Program Compounds in any Program Year during the Program Term (it being understood that such abandonment need not occur entirely in one Program Year); (ii) does not expend on Program Related Costs during any Program Year the full amount of the Program Payment made by John Hancock for such Program Year; (iii) does not reasonably demonstrate in its Annual Research Plan, its intent and reasonable expectation to expend on Program Related Costs during the next Program Year an amount in excess of the Program Payment to be provided by John Hancock for such year; or (iv) does not reasonably demonstrate in its Annual Research Plan its intent and reasonable expectation to expend on Program Related Costs during the Program Term an amount in excess of the Aggregate Spending Target, John Hancock's obligation to make any remaining Program Payments for any succeeding Program Years pursuant to Section 3.1 shall terminate. For the avoidance of doubt, the Program Payments for the Program Year in which such event occurs shall still be due and payable, adjusted only as set forth in the next sentence, if applicable. In addition, in the case of either (i) or (ii) above, Abbott shall (not later than the 10th day following such event) pay to John Hancock (x) the amount, if any, by which the Program Payment made by John Hancock for such year (in the case of (i) above meaning the Program Year in which all Preclinical Programs and Program Compounds were finally abandoned), if any, exceeds one-half of the Program Related Costs actually spent by Abbott during that Program Year and (y) such additional amount that, after giving effect to the payments referred to in this sentence, causes the Program Related Costs for all years in the Program Term to date to have been funded one-third (1/3) by John Hancock and two-thirds (2/3) by Abbott.

3.5 Hancock Funding Obligation. John Hancock's entire obligation hereunder shall be limited to providing the Program Payments set forth in Section 3.1. Abbott shall be solely

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responsible for funding all Program Related Costs in excess of the Program Payments from John Hancock.

ARTICLE 4 PRODUCT RESEARCH AND DEVELOPMENT

4.1 Commercially Reasonable Efforts. Abbott shall be solely responsible for the clinical development, government approval, manufacturing, marketing, sales and distribution of Products. Abbott will use, and will cause each of its Affiliates and Licensees to use, Commercially Reasonable Efforts to pursue the clinical development, government approval, manufacturing, marketing, sales and distribution of Products throughout the Territory. The obligations of Abbott, its Affiliates and Licensees with respect to any Product under this Article 4 are expressly conditioned upon the safety, efficacy and commercial feasibility of each Product, consistent with using Commercially Reasonable Efforts, but no license, assignment or other transfer of rights by Abbott will modify or reduce Abbott's obligations hereunder (except as set forth in Article 14). It is the parties' expectation that under normal circumstances Abbott will file for Regulatory Approval with respect to each Product in Europe within two (2) years from the date of the NDA filing for such Product in the U.S. Territory and in Japan within five (5) years from such NDA filing date; provided, however, that these time frames may be extended or otherwise altered based upon unforeseen circumstances that legitimately impact such regulatory filings in such foreign jurisdictions.

4.2 Marketing and Sale Responsibility. Without limiting the generality of Section 4.1, within six (6) months of obtaining Regulatory Approval for a Product in a given country, Abbott, its Affiliates or Licensees shall commence to market and sell such Product in such country. Abbott's obligation to market and sell a Product shall not apply to a Product in any country if Abbott has not commenced or has ceased marketing and selling such Product in such country substantially on account of adverse business or financial conditions caused by the regulatory authorities or other governmental authorities of such country (including not commencing marketing and selling in a country where the regulatory authorities have price or reimbursement approval and the price or reimbursement approval or that proposed by the regulatory authorities or government authorities is unacceptable to Abbott) which causes the marketing and sale of such Product in such country to be contrary to the financial best interests of John Hancock and Abbott; provided, however, that Abbott, its Affiliates or Licensees shall commence or resume marketing and sale of such Product in such country as soon as reasonably practical after such adverse business or financial conditions cease to exist.

4.3 Failure of Program Compound to Progress.

- (a) Preclinical Programs: ED Program, FTI Program and MMPI Program.
With respect to any Program Compound resulting from a Preclinical Program that Abbott ceases to develop past Phase I Clinical Trial (i.e., does not enter a Phase II Clinical Trial) (a "Failed Early Stage Program

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Compound"), for which Abbott or its Affiliates has or will have one or more other compounds in such respective Preclinical Program (which includes all in-licensed compounds not yet approved for marketing), the next compound to enter Phase I Clinical Trials from such Preclinical Program shall be considered a Program Compound in all respects hereunder, as of the date of the cessation of such Failed Early Stage Program Compound; provided however, with respect to each Preclinical Program, there shall be no more than three Program Compounds substituted under this Section 4.3(a) (for an aggregate maximum of nine (9) such substitutions for all Preclinical Programs). At the time a Preclinical Program becomes a Ceased Program, Abbott shall have no further obligation to provide a substitute for a Failed Early Stage Program Compound.

- (b) Failure of ABT-492 or ABT-510 to Yield a Compound that Enters a Phase II Clinical Trial. If (i) ABT-492 fails to enter a Phase II Clinical Trial, or (ii) ABT-510 fails to enter a Phase II Clinical Trial, then within six (6) months after the failure of the first such Program Compound to enter a Phase II Clinical Trial, Abbott shall substitute a compound in a Phase II Clinical Trial having a commercial value not less than that currently expected for ABT-492 and ABT-510, respectively (as of the date of execution of this Agreement).
- (c) Cessation as a Result of an Acquired Replacement Compound. If Abbott ceases or substantially ceases developing, marketing or selling any Program Compound (that is in Phase I or beyond) or Product (a "Ceased Compound"), and if such cessation or substantial cessation is a result of Abbott's acquisition of a Replacement Compound, then the Replacement Compound shall be considered a Program Compound and/or Product from the date of such acquisition and the Ceased Compound shall no longer be considered a Program Compound.

In the event that the Replacement Compound has been approved for marketing by the FDA and the Ceased Compound has not been approved for marketing by the FDA as of the date of such acquisition, Section 4.3(d) shall apply and the first paragraph of this Section 4.3(c) shall not apply.

In the event that the Ceased Compound has been approved for marketing by the FDA as of the date of such acquisition, John Hancock shall have the option, in its sole discretion, to have Abbott maximize the commercial value of the Ceased Compound pursuant to Section 4.3(d) instead of having the Ceased Compound be subject to this Section 4.3(c).

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- (d) Cessation for Reasons Other than Section 4.3(c). If a Program Compound (that is in Phase I or beyond) or Product becomes a Ceased Compound for any reason not as a result of the acquisition of a Replacement Compound as set forth in Section 4.3(c) above and provided that such Ceased Compound has commercial value, then
- (i) as soon as is practicable Abbott shall maximize the commercial value, if any, of the Ceased Compound to both parties by out-licensing or divesting such Ceased Compound to a third party; provided, however, if the out-licensing or divestiture of such Ceased Compound requires the approval of Taisho Pharmaceutical Co., Ltd. (in the case of Program Compound ABT-773), Eisai Co., Ltd. (in the case of Program Compound ABT-751) or Wakunaga Pharmaceutical Co., Ltd. (in the case of Program Compound ABT-492), pursuant to the respective In-License Agreement, and such entity does not grant such approval, then Abbott shall within a reasonable period of time but not more than three months substitute a compound (which shall thereupon become a "Program Compound") having at least the current and projected potential commercial value as such Ceased Compound;
 - (ii) John Hancock shall be permitted (but have no obligation) to assist in such out-license and/or divestiture effort; and
 - (iii) Abbott shall remunerate John Hancock based on the sales of such Ceased Compound by the third party that has acquired or licensed the Ceased Compound (the "Acquirer") in a manner most consistent with the allocation that would have applied hereunder had such Ceased Compound not been so out-licensed or divested, i.e., in accordance with the royalties and milestones payable hereunder. The appropriate royalty rate payable to John Hancock shall be determined by adding the Acquirer's Net Sales of the Ceased Compound to the total Net Sales of other Products.
- (e) Divestiture. Notwithstanding anything herein to the contrary, Abbott shall not divest or out-license any Program Compound (which shall mean a sale, license or other transfer by Abbott of the right to develop, market and sell any Product containing such Program Compound either (i) in all of North America or (ii) in the countries of Japan and/or the European Union that have at least two-thirds of the total population of Japan and the European Union), without John Hancock's prior written consent, which consent shall not be unreasonably withheld; provided however, if such Program Compound is being divested as a result of direction from the

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Federal Trade Commission to so divest, John Hancock's written consent shall not be required.

- (f) Notice and Information. Abbott shall promptly notify John Hancock upon occurrence of any decision by Abbott to cease or substantially cease developing, marketing or selling any Program Compound or Product. In addition, Abbott shall provide to John Hancock all information reasonably requested by John Hancock related to any Replacement Compound, Program Compound, or Product that is subject to the provisions of this Section 4.3.
- (g) Commercially Reasonable Efforts. Nothing in this Section 4.3 shall lessen any of Abbott's other obligations under this Agreement nor permit Abbott to perform in any manner that is not clearly consistent with using its Commercially Reasonable Efforts hereunder.

4.4 Arm's-Length. Abbott shall not research, develop, manufacture, market, sell, distribute, out-license or otherwise treat any Program Compounds or Products differently, as compared to any other Abbott compounds or products, on account of any of John Hancock's rights hereunder. Furthermore, all distribution agreements, licenses; out-licenses and other agreements relating to the research, development, manufacturing, marketing, sale, distribution, licensing, out-licensing or divestiture of and all other transactions involving any Program Compounds or Products to or with any third party (except to Abbott's Affiliates) shall be on arm's-length terms and conditions.

4.5 In-License Agreements. Abbott shall comply in all material respects with the terms and conditions of the In-License Agreements. Abbott shall not amend the In-License Agreements or waive any of its rights thereunder without John Hancock's prior written consent (such consent not to be unreasonably withheld), unless such amendment or waiver does not have and would not have a material adverse effect on John Hancock's interests hereunder. To the extent that Abbott or any of its Affiliates obtains the right to market, distribute or sell Products containing the Program Compound known as ABT-751 in the Eisai Territory, then sales by Abbott, its Affiliates and Licensees of such Products in such territory shall be included in all respects hereunder (including without limitation in Net Sales and the Territory).

ARTICLE 5 PROGRAM INVENTIONS

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5.1 Ownership. As between Abbott and John Hancock, all inventions, innovations, ideas, discoveries, technology, know-how, methods, data, applications and products (in each case whether or not patentable) arising from the Research Program or otherwise related to the Program Compounds (collectively, the "Program Inventions") shall be exclusively owned by or assigned to Abbott. Abbott shall not divest, out-license or otherwise transfer any of its right, title

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or interest in or to any Program Inventions which would prevent or impair Abbott's ability to fulfill its obligations to John Hancock under this Agreement.

5.2 Patent Prosecution and Maintenance. To the extent it owns a Program Invention or has the contractual right to pursue patent protection for a Program Invention, Abbott will use Commercially Reasonable Efforts to obtain patent protection for the Program Inventions in the Territory. As between Abbott and John Hancock, Abbott shall be responsible for all costs and expenses and control all decisions related to pursuing such patent protection, including the preparation, filing (foreign and/or domestic), prosecution, issuance and maintenance of patent applications or patents covering Program Inventions.

5.3 Enforcement. As between Abbott and John Hancock, Abbott shall have the sole right and authority to enforce the patents or any other rights arising from the Program Inventions (including without limitation the Patents) against any infringers. If Abbott initiates any action or lawsuit to enforce such patents or other rights, it shall be solely responsible for the cost and expense thereof. Abbott will promptly notify John Hancock at such time as it becomes aware of any infringement activities and of any such enforcement actions or lawsuit, and Abbott will provide information concerning them as reasonably requested by John Hancock. All moneys recovered upon the final judgment or settlement of any such action or lawsuit, less the out-of-pocket cost and expense thereof, shall be allocated between Abbott and John Hancock proportional to Abbott's lost profits and John Hancock's lost royalties as a result of such infringement.

ARTICLE 6

MILESTONE PAYMENTS TO JOHN HANCOCK

6.1 [Intentionally omitted].

6.2 Management Fee. On December 1, 2002, 2003 and 2004, Abbott shall pay to John Hancock a management fee, each of which shall be in the amount of Two Million Dollars (\$2,000,000).

6.3 Milestone Notification and Payments. Abbott shall promptly notify John Hancock of the occurrence any of the following events that give rise to Abbott's obligation to make a payment pursuant to this Section 6.3 (each, a "Milestone Payment"). Except as hereinafter limited, Abbott shall pay the following Milestone Payments to John Hancock in the amounts and at the times set forth below with respect to each Program Compound:

- (a) One Million Dollars (\$1,000,000) shall be paid within thirty (30) days after the allowance by the FDA of each Investigational New Drug Application for such Program Compound;

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- (b) Two Million Dollars (\$2,000,000) shall be paid within thirty (30) days after the initiation of each Phase I Clinical Trial with such Program Compound;
- (c) Three Million Dollars (\$3,000,000) shall be paid within thirty (30) days after the initiation of each Phase II Clinical Trial with such Program Compound;
- (d) Four Million Dollars (\$4,000,000) shall be paid within thirty (30) days after the initiation of each Phase III Clinical Trial with such Program Compound; and
- (e) Five Million Dollars (\$5,000,000) shall be paid within thirty (30) days after the filing of each NDA with the FDA for such Program Compound.

In addition, except as hereinafter limited, Abbott shall pay the following Milestone Payments to John Hancock in the amounts and at the times set forth below:

- (f) (i) Twenty Million Dollars (\$20,000,000) shall be paid within thirty (30) days after the Regulatory Approval of the first Product in the U.S. Territory;
- (ii) Ten Million Dollars (\$10,000,000) shall be paid within thirty (30) days after the Regulatory Approval of the second Product in the U.S. Territory; and
- (iii) Ten Million Dollars (\$10,000,000) shall be paid within thirty (30) days after the Regulatory Approval of third Product in the U.S. Territory.

The aggregate of Milestone Payments under Section 6.3(a), (b), (c), (d), and (e) for all Program Compounds shall be limited to Eight Million Dollars (\$8,000,000), and once such aggregate limit has been paid, no further payments shall be due and payable under Sections 6.3(a), (b), (c), (d) or (e).

The aggregate of Milestone Payments under Sections 6.3(a), (b), (c), (d) and (e) for all Program Compounds shall be limited to zero dollars (\$0) during the first Program Year, Two Million Dollars (\$2,000,000) during the second Program Year, and Six Million Dollars (\$6,000,000) during the third Program Year, and once such annual limit has been reached for these particular Program Years, no further payments shall be due under Sections 6.3(a), (b), (c), (d) and (e) for the remainder of such Program Year, provided that any amounts that would have been due to John Hancock but for such annual limits shall be paid in subsequent Program Years so long as the Program Compound to which it relates has not been abandoned, divested or out-licensed by Abbott, subject to the Eight Million Dollar (\$8,000,000) limitation set forth above. Subject to

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the limitations above, the Milestone Payments under Sections 6.3(a), (b), (c), (d) and (e) may be made more than once with respect to each Program Compound.

The aggregate of Milestone Payments under Section 6.3(f) for all Program Compounds shall be limited to Forty Million Dollars (\$40,000,000), and once such aggregate limit has been paid, no further payments shall be due and payable under Section 6.3(f). In addition, Milestone Payments under Section 6.3(f) shall not be paid more than once for any particular Program Compound.

Exhibit 1.40 sets forth the current stage of clinical development for each Program Compound.

ARTICLE 7 ROYALTIES

7.1 Royalty Rates. Subject to the limitation set forth below, Abbott shall pay to John Hancock royalties equal to the following percentages of Net Sales, aggregated on a yearly basis, of all Products in the Territory:

<u>Royalty percentage</u>	<u>Yearly Net Sales (in millions) of all Products in the Territory</u>
8.5% of those Net Sales	up to \$400
and then 4% of those Net Sales	in excess of \$400 up to \$1,000
and then 1% of those Net Sales	in excess of \$1,000 up to \$2,000
and then 0.5% of those Net Sales	in excess of \$2,000

Net Sales shall be aggregated yearly (i) in the case of the U.S. Territory, on a calendar year basis, together with (ii) in the case of the International Territory, on a December 1 to November 30 basis, in each case consistent with the determination of Quarterly Reporting Periods.

7.2 Royalty Term. The duration of the obligation to make royalty payments on each Product shall be determined on a country-by-country basis and shall last for the duration of the Royalty Term in each given country for such Product.

ARTICLE 8 ROYALTY REPORTS AND ACCOUNTING

8.1 Reports. Exchange Rates. With respect to every Quarterly Reporting Period for which Abbott is obligated to pay any royalty hereunder, Abbott shall furnish to John Hancock a single written report for such Quarterly Reporting Period within sixty (60) days after the end of such Quarterly Reporting Period (that is, within sixty (60) days after each March 31, June 30, September 30 and December 31, as the case may be) showing in reasonably specific detail:

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- (a) the total gross sales in each country for each Product sold by Abbott, its Affiliates and Licensees in the Territory and the detailed calculation of Net Sales from gross sales in each country for each Product;
- (b) the royalties payable in Dollars, if any, which shall have accrued hereunder;
- (c) the dates of the First Commercial Sale of each Product in any country in the Territory during such Quarterly Reporting Period; and
- (d) the exchange rates used in determining the amount of Dollars.

With respect to sales of Products invoiced in Dollars, the gross sales, Net Sales (including all adjustments and deductions permitted to be made hereunder in calculating the same), and royalties payable shall be expressed in Dollars. With respect to sales of Products invoiced in a currency other than Dollars, the gross sales, Net Sales (including all adjustments and deductions permitted to be made hereunder in calculating the same) and royalties payable shall be expressed in their Dollar equivalent, calculated using the Inter Bank rate set forth in the International Report published by International Reports Inc. as Foreign Exchange Rates quoted in New York on the day nearest the last business day of the Quarterly Reporting Period.

8.2 Audits.

- (a) Upon the written request of John Hancock and, in the absence of any breach by Abbott hereunder, not more than once in each calendar year, Abbott shall permit John Hancock and an independent certified public accounting firm of nationally recognized standing, selected by John Hancock and reasonably acceptable to Abbott, at John Hancock's expense, to have access during normal business hours to such of the records of Abbott, its Affiliates and Licensees to verify the accuracy of the royalty reports and the amounts and calculation of any payments required hereunder for any year ending not more than five (5) years prior to the date of such request.
- (b) If such accounting firm concludes that additional royalties or other payments were owed during such period, Abbott shall have the option to invoke the proceedings of Section 16.7 below or pay the additional royalties or other payments within thirty (30) days after the date John Hancock delivers to Abbott such accounting firm's written report so concluding. The reasonable fees and expenses charged by such accounting firm shall be paid by John Hancock; provided, however, if the audit discloses that the amounts payable by Abbott for any Quarterly Reporting Period are more than one hundred five percent (105%) of the royalties

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actually paid for such period, then Abbott shall pay the reasonable fees and expenses charged by such accounting firm.

- (c) Abbott shall cause its Affiliates to, and shall include in each license granted by it relating to a Program Compound or Product a provision requiring the Licensee to, (i) make reports to Abbott, (ii) keep and maintain records of Net Sales made pursuant to such license and (iii) grant access to such records by John Hancock and its accounting firm or other auditor to the same extent required of Abbott under this Agreement.
- (d) All reports and payments not disputed as to correctness by John Hancock within five (5) years after receipt thereof shall thereafter conclusively be deemed correct for all purposes, and Abbott, its Affiliates and Licensees shall be released from any liability or accountability with respect to such reports and payments.

8.3 Confidential Financial Information. John Hancock shall treat all information subject to review under this Article 8, and shall cause its accounting firm to agree to treat all such information, in accordance with the provisions of Article 10.

8.4 Accounting Principles. All accounting hereunder, including without limitation all determinations of gross sales, Net Sales (including all adjustments and deductions permitted to be made hereunder in calculating the same), Program Related Costs and all calculations underlying such determinations, shall be made in accordance with generally accepted accounting principles as in effect in the United States, consistently applied.

ARTICLE 9 PAYMENTS

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9.1 Payment Terms. With respect to every Quarterly Reporting Period for which Abbott is obligated to pay a royalty hereunder, such royalties shall be due and payable in a single payment within sixty (60) days of the end of such Quarterly Reporting Period (that is, within sixty (60) days of each March 31, June 30, September 30 and December 31, as the case may be). Payment of royalties may be made in advance of such due date.

9.2 Payment Method. All royalties and other payments by Abbott to John Hancock under this Agreement shall be made by bank wire transfer in immediately available funds in accordance with the instructions set forth on Exhibit 9.2 attached hereto or in accordance with such other instructions as John Hancock may give from time to time.

9.3 Late Payments. Each party shall pay interest to the other on the aggregate amount of any payments by it that are not paid on or before the date such payments are due under this Agreement, including, without limitation, any disputed payments or payments resulting from any

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audit, at a rate per annum equal to the lesser of (a) the prime rate of interest plus two hundred (200) basis points as reported by Citibank, N.A. in New York, from time to time (with any change in such reported rate being effective immediately for purposes hereof), or (b) the highest rate permitted by applicable law, calculated on the number of days such payments is delinquent until paid in full in cash. All such amounts shall be payable upon demand.

ARTICLE 10 CONFIDENTIALITY

10.1 Nondisclosure Obligations. Except as otherwise provided in this Article 10, during the term of the Agreement and for a period of ten (10) years thereafter, (a) John Hancock shall maintain in confidence in accordance with such procedures as are adopted by John Hancock to protect its own confidential information and shall use only for purposes of this Agreement (including, without limitation, enforcement of the terms hereof), information and data related to the Program Compounds or Products; and (b) John Hancock shall also maintain in confidence in accordance with such policies, and use only for purposes of this Agreement, all information and data supplied by Abbott under this Agreement, which if disclosed in writing is marked "confidential", if disclosed orally is promptly thereafter summarized and confirmed in writing to the other party and marked "confidential", or if disclosed in some other form is marked "confidential."

10.2 Permitted Disclosures. For purposes of this Article 10, information and data described in clause (a) or (b) above shall be referred to as "Confidential Information". John Hancock may disclose Confidential Information as required by applicable law, regulation or judicial process, provided that John Hancock shall, if legally permitted, give Abbott prompt written notice thereof. The obligation not to disclose or use Confidential Information shall not apply to any part of such Confidential Information that (i) is or becomes patented, published or otherwise part of the public domain other than by acts or omissions of John Hancock in contravention of this Agreement; or (ii) is disclosed to John Hancock by a third party, provided such Confidential Information was not obtained on a confidential basis by such third party from Abbott, its Affiliates or Licensees; or (iii) prior to disclosure under the Agreement, was already in the possession of John Hancock, provided such Confidential Information was not obtained directly or indirectly from Abbott, its Affiliates or Licensees under an ongoing obligation of confidentiality; or (iv) is disclosed in a press release agreed to by both parties under Section 10.3 below.

10.3 Publicity Review. Without the prior written consent of the other party, neither party shall make any statement to the public regarding the execution and/or any other aspect of the subject matter of this Agreement and John Hancock shall not make any statement to the public regarding any work under the Research Program; provided that, Abbott may make statements to the public regarding work done under the Research Program (without reference to or mention of John Hancock) and the commercialization of any Products resulting therefrom in accordance with its standard business practices. John Hancock and Abbott shall not disclose any

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terms or conditions of this Agreement to any third party without the prior consent of the other party, except as set forth above in this Section 10.3 or as required by applicable law, regulation or court order. The parties agree not to issue a press release announcing the execution of this Agreement.

ARTICLE 11
TERM AND TERMINATION

11.1 Expiration. This Agreement shall expire upon satisfaction of Abbott's obligations to pay royalties under Section 7.2 and all other amounts under this Agreement.

11.2 Termination; Material Breach. It is the parties' express intent that consideration shall be given to remedying any breach of this Agreement through the payment of monetary damages or such other legal or equitable remedies as shall be appropriate under the circumstances and that there shall only be a limited right to terminate this Agreement under the following circumstances.

- (a) In the event that the court, in accordance with the procedures set forth in Section 16.2, has issued a ruling that John Hancock has breached its obligation under Section 3.1 of this Agreement (obligation to make payments), and such ruling specified the actions to be taken by John Hancock on account of such breach, and John Hancock has failed to comply with the terms of such ruling within the time period specified therein for compliance and the time for any appeal has expired without the submission of an appeal, then, in addition to all other rights available to Abbott under law and equity, including its right to enforce such ruling in court, Abbott shall have the right to terminate the Agreement as a result of John Hancock's failure to abide by the terms of this Agreement and such ruling.
- (b) In the event that the court, in accordance with the procedures set forth in Section 16.2, has issued a ruling that Abbott has breached a material obligation under this Agreement, and such ruling specified the actions to be taken by Abbott on account of such breach, and Abbott has failed to comply with the terms of such ruling within the time period specified therein for compliance and the time for any appeal has expired without the submission of an appeal, then, in addition to all other rights available to John Hancock under law and equity, including its right to enforce such ruling in court, John Hancock shall have the right to terminate the Agreement, each as a result of Abbott's failure to abide by the terms of this Agreement and such ruling.

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11.3 Effect of Expiration or Termination. Expiration or, if applicable, termination of this Agreement shall not relieve the parties of any obligation accruing prior to such expiration or termination. The provisions of Articles 8 (Royalty Reports and Accounting), 10 (Confidentiality), 11 (Term and Termination), 12 (Warranties and Indemnification) and 16 (Miscellaneous) shall survive the expiration or termination of this Agreement.

ARTICLE 12
WARRANTIES AND INDEMNITY

12.1 John Hancock Representations and Warranties. John Hancock represents and warrants to Abbott that as of the Execution Date:

- (a) The execution and delivery of this Agreement and the performance of the transactions contemplated hereby have been duly authorized by all appropriate John Hancock corporate action. This Agreement constitutes John Hancock's valid and binding legal obligation, enforceable against it in accordance with its terms.
- (b) The performance by John Hancock of any of the terms and conditions of this Agreement on its part to be performed does not and will not constitute a breach or violation of its organizational documents or any other material agreement or understanding, written or oral, to which it is a party or any law, statute, rule or regulation by which it is bound.
- (c) No consent, approval, license or authorization of, or designation, declaration or filing with, any court or governmental authority is or will be required on the part of John Hancock in connection with the execution, delivery and performance by John Hancock of this Agreement or any other agreements or instruments executed and delivered by John Hancock in connection herewith or therewith, including, without limitation, any filings pursuant to federal or state securities laws or pursuant to any federal anti-trust laws.
- (d) Neither John Hancock nor any person acting on its behalf (i) has taken or will take any action which would subject this Agreement and the consummation of the transactions contemplated hereby to the registration or qualification requirements of any federal or state securities laws, (ii) has dealt with any broker, finder or other similar person in connection with the transactions contemplated by this Agreement or (iii) is under any obligation to pay any broker's fee, finder's fee or commission in connection with such transactions.

12.2 Abbott Representations and Warranties. Abbott represents and warrants to John Hancock that as of the Execution Date:

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- (a) The execution and delivery of this Agreement and the performance of the transactions contemplated hereby have been duly authorized by all appropriate Abbott corporate action. This Agreement constitutes Abbott's valid and binding legal obligation, enforceable against it in accordance with its terms.
- (b) The performance by Abbott of any of the terms and conditions of this Agreement on its part to be performed does not and will not constitute a breach or violation of its organizational documents or any other agreement or understanding, written or oral, to which it is a party or any law, statute, rule or regulation by which it is bound.
- (c) No consent, approval, license or authorization of, or designation, declaration or filing with, any court or governmental authority is or will be required on the part of Abbott in connection with the execution, delivery and performance by Abbott of this Agreement or any other agreements or instruments executed and delivered by Abbott in connection herewith or therewith, including, without limitation, any filings pursuant to federal or state securities laws or pursuant to any federal anti-trust laws, except those consents, approvals, licenses, authorizations, and other requirements imposed by governmental authorities (both U.S. and foreign) and such declarations and filings with governmental authorities (both U.S. and foreign) required in the normal course of pharmaceutical research, development, marketing and sale.
- (d) Set forth on Exhibit 12.2(d) is the full name, chemical name, detailed description of the stage of development and current status, for each Program Compound. Set forth on Exhibit 1.6 in each Annual Research Plan is a description of projected milestones and dates thereof, projected year of NDA filing, and projected costs to be incurred by Abbott during the Program Term, for each Program Compound. Such projections were prepared in good faith and with due care based on reasonable assumptions, and represent the reasonable estimate of Abbott based on information available as of the date of such projections and as of the date hereof; it being agreed that such projections do not constitute any warranty as to the future performance of the Program Compounds and that actual results may vary from such projections.
- (e) Set forth on Exhibit 12.2(e) is a list and description of all domestic and foreign patents, patent rights, patent applications and all patent applications that are in the process of being prepared that are owned by or registered in the name of Abbott, or of which Abbott is a licensee or in which Abbott has any right, which claim any of the Program Compounds (the "Patents"). Abbott solely owns all of the Patents, except as indicated

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on Exhibit 12.2(e). All of the material Patents have been duly filed in or issued by the United States Patent and Trademark Office or the equivalent foreign patent office identified on Exhibit 12.2(e), as the case may be, and have been properly maintained and renewed in accordance with all applicable laws and regulations. With respect to the Patents that it does not own, Abbott has an exclusive and valid license thereunder to develop, make, have made, use, market and sell (with the right to sublicense) the applicable Program Compounds in the entire Territory; provided however, (i) with respect to Italy, Abbott has such rights that are co-exclusive with Eisai Co. Ltd. for the Program Compound known as ABT-751 and (ii) with respect to Japan, Abbott has such rights that are co-exclusive with Taisho Pharmaceutical Co., Ltd. for the Program Compound known as ABT-773. Except with respect to the Preclinical Programs, to Abbott's knowledge, it is not necessary to obtain or license any patents, patent rights, inventions, copyrights, manufacturing processes, formulae, trade secrets, proprietary rights or know-how that it does not currently have in order to (i) develop, make, have made, use, market and sell the Program Compounds or (ii) conduct the Research Program as heretofore conducted and as proposed to be conducted. Except with respect to those Program Compounds that are the subject of In-License Agreements, the Program Compounds are owned exclusively by Abbott, free and clear of any liens or encumbrances of any other person and, to Abbott's knowledge, Abbott does not require the consent of any other person to develop, make, have made, use, market and sell the Program Compounds.

- (f) Except as set forth in Exhibit 12.2(f) (but in any event, as of the Execution Date, such matters are not, and could not reasonably be expected to be material), Abbott has not received any communications alleging that, and no claim is pending or, to the knowledge of Abbott, threatened to the effect that, the operations of Abbott with respect to the Research Program or the Program Compounds infringe upon or conflict with (or will infringe or conflict with) the asserted rights of any other person under any domestic or foreign patent, trademark, service mark, copyright, trade secret, proprietary right or any other intellectual property right, and, except for the Preclinical Programs, there is no material basis known to Abbott for any such claim (whether or not pending or threatened). No claim is pending or, to the knowledge of Abbott, threatened to the effect that any of the Patents are invalid or unenforceable by Abbott, and there is no material basis known to Abbott for any such claim (whether or not pending or threatened). The publication of any material technical information with respect to the Program Compounds developed by and belonging to Abbott is subject to review and approval under Abbott's existing procedures.
- (g) Except for the In-License Agreements and customary employment and consulting agreements with Abbott's employees and consultants, there are

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no outstanding options, licenses, or agreements of any kind relating to the Patents or any of the Program Compounds or the transactions contemplated by this Agreement, which license the Patents or any technical information developed in the course of the clinical development program to any third party to register, market or sell any of the Program Compounds or Products.

- (h) To the knowledge of Abbott with respect to the Research Program and each of the Program Compounds, Abbott is not now, and in performing its obligations hereunder will not be, in any way making an unlawful or wrongful use of any confidential information, know-how, or trade secrets of any other person.
- (i) Neither this Agreement nor any Exhibit to this Agreement (including the compound reports attached as Exhibit 12.2(i) hereto (the "Compound Reports")) contains any untrue statement of material fact or omits to state any material fact necessary to make the statements contained herein or therein not misleading. There is no fact known to Abbott (other than generally available information concerning the pharmaceutical industry in general) as of the date of this Agreement that has not been disclosed in this Agreement or any Exhibit to this Agreement which has resulted in, or could reasonably be expected to result in, a material adverse effect on the prospects or condition (including safety, efficacy, scientific viability or commercial) of the Research Program or any of the Program Compounds.
- (j) Neither Abbott nor any person acting on its behalf (i) has taken or will take any action which would subject this Agreement and the consummation of the transactions contemplated hereby to the registration or qualification requirements of any federal or state securities laws, (ii) has dealt with any broker, finder or other similar person in connection with the transactions contemplated by this Agreement or (iii) is under any obligation to pay any broker's fee, finder's fee or commission in connection with such transactions.
- (k) Other than generally publicized actions, proceedings or investigations concerning the pharmaceutical industry in general, there is no action, proceeding or investigation pending or, to the knowledge of Abbott, threatened which (i) questions the validity of this Agreement or any action taken or to be taken by Abbott pursuant thereto or (ii) which has resulted in, or could reasonably be expected to result in, a material adverse effect on the prospects or condition (including safety, efficacy, scientific viability or commercial) of the Research Program or any of the Program Compounds.

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- (l) With respect to the Research Program and each of the Program Compounds, Abbott has (and in the future will have) obtained, to the extent permitted by law, from each of its employees, consultants, Affiliates and Subcontractors an agreement that reasonably protects Abbott's interest in the Program Inventions, Program Compounds and Products.
- (m) With respect to each Program Compound, since the date of its respective Compound Report, to the knowledge of Abbott, no condition, circumstance or fact has arisen (other than generally available information concerning the pharmaceutical industry in general) nor has Abbott made any change in the conduct of the Research Program which, individually or in the aggregate, has resulted in, or could reasonably be expected to result in, a material adverse effect on the prospects or condition (including safety, efficacy, scientific viability or commercial) of such Program Compounds.
- (n) Each In-License Agreement is valid, binding and in full force and effect, and there is no event which has occurred or exists, which constitutes or which, with notice and/or the passage of time, would constitute a material default or breach under any such contract by Abbott or, to Abbott's knowledge, any other party thereto, or would cause the acceleration of any obligation of any party thereto or give rise to any right of termination or cancellation thereof. Abbott has no reason to believe that the parties to each In-License Agreement will not fulfill their obligations thereunder in all material respects or that such parties do not have the right to grant the licenses granted thereunder. Abbott has no reason to believe that it will not fulfill its obligations under the In-License Agreements. Under the Eisai Agreement, neither Abbott nor its Affiliates has the right to market, distribute or sell Products containing the Program Compound known as ABT-751 in the Eisai Territory (with the exception of Italy).

12.3 No Conflict. Abbott and John Hancock represent and warrant that this Agreement does not, and will not, conflict with any other right or obligation provided under any other agreement or obligation that Abbott or John Hancock has with or to any third party.

12.4 Compliance with Law. Each party represents and warrants to the other that it will comply with all applicable laws, regulations and guidelines in connection with its performance of its obligations and rights pursuant to this Agreement, including the regulations of the United States and any other relevant nation concerning any export or other transfer of technology, services or products.

12.5 No Other Warranties. EACH PARTY TO THIS AGREEMENT AGREES THAT, EXCEPT FOR THE REPRESENTATIONS AND WARRANTIES CONTAINED IN THIS AGREEMENT, NEITHER PARTY MAKES ANY OTHER REPRESENTATIONS OR

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WARRANTIES, AND EACH HEREBY DISCLAIMS ANY OTHER REPRESENTATIONS OR WARRANTIES MADE BY ITSELF OR ANY OF ITS OFFICERS, DIRECTORS, EMPLOYEES, AGENTS, FINANCIAL AND LEGAL ADVISORS OR OTHER REPRESENTATIVES, WITH RESPECT TO THE EXECUTION AND DELIVERY OF THIS AGREEMENT OR THE TRANSACTIONS CONTEMPLATED BY THIS AGREEMENT, NOTWITHSTANDING THE DELIVERY OR DISCLOSURE TO THE OTHER OR THE OTHER'S REPRESENTATIVES OF ANY DOCUMENTATION OR OTHER INFORMATION WITH RESPECT TO ANY ONE OR MORE OF THE FOREGOING.

12.6 General Indemnification of John Hancock. Abbott shall indemnify and hold John Hancock and its Affiliates, agents, directors and employees harmless, and hereby forever releases and discharges John Hancock and its Affiliates, agents, directors and employees, from and against all Losses related to or arising out of, directly or indirectly, (i) any negligence, recklessness or intentional misconduct of Abbott or its Affiliates, agents, directors, employees, Subcontractors, licensees (including Licensees) or sublicensees in connection with the Research Program, Program Compounds or Products, or (ii) any manufacture, use, storage, distribution or sale of the Program Compounds or Products by anyone, including without limitation all Losses related to any personal injury or death, or (iii) any breach by Abbott of its representations, warranties or obligations hereunder, or (iv) the consummation of the transactions contemplated hereby, except, in each case, to the extent any such Losses are the result of (A) any breach by John Hancock of its representations, warranties or obligations hereunder, or (B) any negligence, recklessness, or intentional misconduct by John Hancock or its Affiliates, agents, directors, employees.

12.7 Indemnification Relating to Certain In-Licensed Compounds. Abbott shall indemnify and hold John Hancock and its Affiliates, agents, directors and employees harmless, and hereby forever releases and discharges John Hancock and its Affiliates, agents, directors and employees, from and against all Losses to the extent related to or arising out of, directly or indirectly, the fact that Abbott's rights in the Program Compounds known as ABT-773, ABT-492 and ABT-751 and the Patents and other patent rights, copyrights, trade secret rights and other intellectual property rights related thereto arise from the Taisho Agreement, the Wakunaga Agreement or the Eisai Agreement respectively, rather than being owned by Abbott as with the other Program Compounds. Accordingly, by way of example and without limiting the foregoing, Abbott's indemnification obligation under this Section 12.7 will arise upon (i) any impairment of Abbott's ability to perform its obligations under this Agreement in the entire Territory as a result of Abbott's rights to the Program Compounds known as ABT-773, ABT-442 and ABT-751 arising from the Taisho Agreement, Wakunaga Agreement and the Eisai Agreement, respectively or (ii) a breach by Abbott or any other person of any of the In-License Agreements; except, in each case, to the extent any such Losses are the result of (A) any breach by John Hancock of its representations, warranties or obligations hereunder, or (B) any negligence, recklessness, or intentional misconduct by John Hancock or its Affiliates, agents, directors, employees.

12.8 Procedure. If John Hancock or any of its Affiliates, agents, directors or employees (each, an "Indemnitee") intends to claim indemnification under this Article 12, it shall

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promptly notify Abbott (the "Indemnitor") of any Loss or action in respect of which the Indemnitee intends to claim such indemnification, and the Indemnitor shall have the right to participate in, and, to the extent the Indemnitor so desires, to assume the defense thereof with counsel selected by the Indemnitor; provided, however, that an Indemnitee shall have the right to retain its own counsel, with the fees and expenses of such counsel to be paid by the Indemnitor, if representation of such Indemnitee by the counsel retained by the Indemnitor would be inappropriate due to actual or potential differing interests between such Indemnitee and any other party represented by such counsel in such proceedings. The indemnity obligation in this Article 12 shall not apply to amounts paid in settlement of any loss, claim, damage, liability or action if such settlement is effected without the consent of the Indemnitor, which consent shall not be withheld unreasonably or delayed. The failure to deliver notice to the Indemnitor within a reasonable time after the commencement of any such action, if materially prejudicial to its ability to defend such action, shall relieve the Indemnitor of any liability to the Indemnitee under this Article 12 only to the extent arising from the tardiness or absence of such notice, but the omission so to deliver notice to the Indemnitor will not relieve it of any liability that it may have to any Indemnitee otherwise than under this Article 12. The Indemnitee shall cooperate fully with the Indemnitor and its legal representatives in the investigation of any action, claim or liability covered by indemnification under this Article 12, at the expense of the Indemnitor.

12.9 Insurance. Abbott shall at its expense maintain, through self-insurance or otherwise, product liability insurance with respect to the development, manufacture, sale and use of Products and Program Compounds in such amounts and on such terms as Abbott customarily maintains with respect to its other similar products. Abbott shall maintain such insurance for so long as it continues to develop, manufacture or sell any Products or Program Compounds, and thereafter for so long as Abbott customarily currently maintains such insurance.

12.10 Acknowledgment. Abbott and John Hancock acknowledge that Abbott has not delivered or disclosed the contents of any of the In-License Agreements to John Hancock.

ARTICLE 13 FORCE MAJEURE

Neither party shall be held liable or responsible to the other party nor be deemed to have defaulted under or breached this Agreement for failure or delay in fulfilling or performing any term of this Agreement when such failure or delay is caused by or results from causes beyond the reasonable control of the affected party including but not limited to fire, floods, embargoes, war, acts of war (whether war be declared or not), insurrections, riots, civil commotions, strikes, lockouts or other labor disturbances, acts of God or acts, omission or delays in acting by any governmental authority; provided that such affected party shall provide the other party with prompt notice of the circumstances surrounding such a material failure or delay, after which the parties will amend this Agreement upon terms and conditions that are mutually agreeable to equitably account to the party that does not so fail or delay.

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JH 008110

Deposition Exhibit 1

P's Exhibit 32

Part 2

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ARTICLE 14
ASSIGNMENT

Except as expressly provided hereunder, this Agreement may not be assigned or otherwise transferred, nor may any right or obligations hereunder be assigned or transferred by either party without the consent of the other party; and, in addition, both parties acknowledge and agree that the obligations of Abbott hereunder are personal to Abbott and that Abbott is uniquely qualified to perform them; provided, however, that either party shall be obligated to assign this Agreement and its rights and obligations hereunder in connection with the transfer or sale of all or substantially all of its business, or in the event of its merger or consolidation or change in control or similar transaction and in such event such party shall cause its successor or transferee in such transaction to assume all of the obligations of such party. Any permitted assignee shall assume all obligations of its assignor under this Agreement. Notwithstanding the foregoing, John Hancock shall have the right to assign its rights (but not its obligation to make payments under Section 3.1) in whole or in part (provided that, any assignment in part shall mean an assignment of a pro rata share of the entirety of John Hancock's rights hereunder) without Abbott's consent (and following any such assignment all references to John Hancock herein shall include any such assignee), provided that: (i) each assignee of such rights must be a bank, insurance company or other institutional investor; (ii) there shall be no greater than five (5) assignees, (iii) if any such assignee is located outside the United States John Hancock shall notify Abbott at least sixty (60) days in advance, (iv) if any claim arises with respect to Abbott's failure to make payments, then during the term of the Research Program (but in any event not longer than four years from the date hereof), any such claim must be brought by John Hancock, and not an assignee. In soliciting potential assignees for such right to payments, John Hancock shall not disclose any Confidential Information hereunder to more than ten (10) potential assignees. Any potential assignee to whom John Hancock discloses Confidential Information must have executed a confidentiality agreement no less stringent than Article 10 hereof. Furthermore, if John Hancock plans to exercise its right of assignment hereunder, John Hancock shall first notify Abbott of such plans in writing. Abbott shall have the first right to negotiate the purchase of any such assignment rights. If within fifteen (15) days after receipt of such notice the parties have not agreed upon the principal terms of such arrangement or if within forty-five (45) days after receipt of such notice the parties have not executed a final written agreement reflecting such arrangement, then John Hancock shall have no further obligations to Abbott with respect to such first right of negotiation.

ARTICLE 15
SEVERABILITY

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Each party hereby agrees that it does not intend its execution and delivery hereof or its performance hereunder to violate any public policy, statutory or common laws, rules, regulations, treaty or decision of any government agency or executive body thereof of any country or community or association of countries. If and to the extent any term or provision of this Agreement is held to be invalid, illegal or unenforceable by a court or other governmental

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authority of competent jurisdiction, such invalidity, illegality or unenforceability shall not affect any other term or provision of this Agreement, which shall remain in full force and effect. The holding of a term or provision to be invalid, illegal or unenforceable in a jurisdiction shall not have any effect on the application of the term or provision in any other jurisdiction.

ARTICLE 16
MISCELLANEOUS

16.1 Notices. Any consent, notice or report required or permitted to be given or made under this Agreement by one of the parties hereto to the other shall be in writing, delivered personally or by facsimile (and promptly confirmed by personal delivery, U.S. first class mail or courier), U.S. first class mail or courier, postage prepared (where applicable), addressed to such other party at its address indicated below, or to such other address as the addressee shall have last furnished in writing to the addressor and (except as otherwise provided in this Agreement) shall be effective upon receipt by the addressee.

If to John Hancock: John Hancock Life Insurance Company
200 Clarendon Street, T-57
Boston, MA 02117
Attention: Bond & Corporate Finance Group
Telephone: 617-572-9624
Fax: 617-572-1628

copy to: John Hancock Life Insurance Company
200 Clarendon Street, T-50
Boston, MA 02117
Attention: Investment Law Division
Telephone: 617-572-9205
Fax: 617-572-9268

and, if it relates to making or not making a royalty payment or Milestone Payment hereunder,

copy to: John Hancock Life Insurance Company
200 Clarendon Street
Boston, MA 02117
Attention: Manager, Investment Accounting Division, B-3
Fax: 617-572-0628

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If to Abbott: Abbott Laboratories
Dept. 309, Bldg. AP30
200 Abbott Park Road
Abbott Park, IL 60064-3537
Attention: President, Pharmaceutical Products Division
Telephone: 847-938-6863
Fax: 847-938-5383

copy to: General Counsel
Abbott Laboratories
Dept. 364, Bldg. AP6D
100 Abbott Park Road
Abbott Park, IL 60064-6020
Telephone: 847-937-8905
Fax: 847-938-6277

16.2 Applicable Law. The Agreement shall be governed by and construed in accordance with the internal laws of the State of Illinois. With respect to any action hereunder, Abbott, to the extent that it may lawfully do so, hereby consents to service of process, and to be sued, in the Commonwealth of Massachusetts and consents to the exclusive jurisdiction of the courts of the Commonwealth of Massachusetts and the United States District Court for the District of Massachusetts, as well as to the jurisdiction of all courts to which an appeal may be taken from such courts, for the purpose of any suit, action or other proceeding arising out of any of its obligations hereunder or thereunder or with respect to the transactions contemplated hereby or thereby, and expressly waives any and all objections it may have as to venue in any such courts. Abbott further agrees that a summons and complaint commencing an action or proceeding in any of such courts shall be properly served and shall confer personal jurisdiction if served personally or by certified mail to it at its address for notices as provided in this Agreement or as otherwise provided under the laws of the Commonwealth of Massachusetts. THE PARTIES EACH IRREVOCABLY WAIVE ALL RIGHT TO A TRIAL BY JURY IN ANY SUIT, ACTION OR OTHER PROCEEDING INSTITUTED BY OR AGAINST IT IN RESPECT OF ITS OBLIGATIONS HEREUNDER OR THEREUNDER OR THE TRANSACTIONS CONTEMPLATED HEREBY OR THEREBY.

16.3 Entire Agreement. This Agreement contains the entire understanding of the parties with respect to the subject matter hereof. All express or implied agreements and understandings, either oral or written, with respect to the subject matter hereof heretofore made are expressly merged in and made a part of this Agreement. This Agreement may be amended, or any term hereof modified, only by a written instrument duly executed by both parties hereto.

16.4 Headings. The captions to the several Articles and Sections hereof are not a part of this Agreement, but are merely guides or labels to assist in locating and reading the several Articles and Sections hereof.

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JH 008113

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16.5 Independent Contractors. It is expressly agreed that John Hancock and Abbott shall be independent contractors and that the relationship between the two parties shall not constitute a partnership, joint venture or agency. Neither John Hancock nor Abbott shall have the authority to make any statements, representations or commitments of any kind, or to take any action, which shall be binding on the other, without the prior written consent of the other party to do so.

16.6 Performance By Affiliates, Licensees and Subcontractors. The parties recognize that Abbott may carry out certain obligations under this Agreement through performance by its Affiliates, Licensees and Subcontractors (but in no event shall that relieve Abbott of any of its obligations hereunder). Abbott guarantees that the activities of its Affiliates, Licensees and Subcontractors under this Agreement shall comply with this Agreement.

16.7 Dispute Resolution. The parties shall attempt to amicably resolve disputes arising between them regarding the validity, construction, enforceability or performance of the terms of this Agreement, and any differences or disputes in the interpretation of the rights, obligations, liabilities and/or remedies hereunder, which have been identified in a written notice from one party to the other, by good faith settlement discussions between the President of Abbott's Pharmaceutical Products Division and a Managing Director of John Hancock or his designee. The parties agree that, prior to filing any lawsuit regarding any dispute that arises in connection with this Agreement (with the exception of any action demanding a preliminary injunction), such representatives shall meet and attempt to amicably resolve such dispute within thirty (30) days after the receipt of such written notice.

16.8 Waiver. The waiver by either party hereto of any right hereunder or the failure to perform or of a breach by the other party shall not be deemed a waiver of any other right hereunder or of any other breach or failure by said other party whether of a similar nature or otherwise.

16.9 Counterparts. This Agreement may be executed in two or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument.

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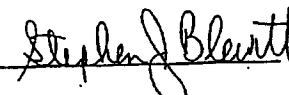
CONFIDENTIAL
JH 008114

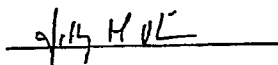
-35-

IN WITNESS WHEREOF, the parties have executed this Agreement as of the date first set forth above.

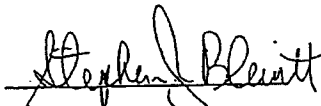
JOHN HANCOCK LIFE
INSURANCE COMPANY

ABBOTT LABORATORIES

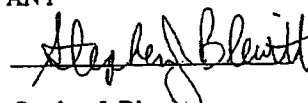
By: 
Name: Stephen J. Blewitt
Title: Managing Director
Date: March 13, 2001

By: 
Name: Jeffrey M. Leiden, Ph.D., M.D.
Title: Executive Vice President, Pharmaceuticals
and Chief Scientific Officer
Date: March 13, 2001

JOHN HANCOCK VARIABLE
LIFE INSURANCE COMPANY

By: 
Name: Stephen J. Blewitt
Title: Authorized Signatory
Date: March 13, 2001

INVESTORS PARTNER LIFE INSURANCE
COMPANY

By: 
Name: Stephen J. Blewitt
Title: Authorized Signatory
Date: March 13, 2001

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EXHIBIT 1.6

FIRST ANNUAL RESEARCH PLAN

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JH 008116

Ketolid Oral & IV (ABT-773)
Annual Development Plan
Exhibit 1.6

Therapeutic Area	Antibacterial		Spending		Total
	Indications	Description	Current Time Line	Projected Spending by Year	
Adult Tablet: Community-acquired respiratory infections. IV: Step-down therapy in community-acquired hospitalized pneumonia.	<ul style="list-style-type: none"> - ABT-773 is a potent ketolide with strong activity against most macrolide resistant strains, while maintaining the broad spectrum coverage of clarithromycin. - Product will be available as tablet and IV formulation. - ABT-773 will address the major unmet medical needs of increasing resistance to current ampicic agents, particularly S. pneumoniae. - Maintains clar's claim of "Spans the spectrum" (G+, G-, atypicals). - Cover key G+ resistant strains (S. pneumoniae, S. pyogenes). - Tablet dosing is 150mg QD or 150mg BID dosing based on severity of indications. - Tablet: 8 days for ABECs, pharyngitis, 10 days for AMS and CAP. - Incidence of GI side effects equal to clar (assuming comparable drug levels to tablet). - COGS target \$2,500/kg at launch for tablet. 	<ul style="list-style-type: none"> - ABT-773 is a potent ketolide with strong activity against most macrolide resistant strains, while maintaining the broad spectrum coverage of clarithromycin. - Product will be available as tablet and IV formulation. - ABT-773 will address the major unmet medical needs of increasing resistance to current ampicic agents, particularly S. pneumoniae. - Maintains clar's claim of "Spans the spectrum" (G+, G-, atypicals). - Cover key G+ resistant strains (S. pneumoniae, S. pyogenes). - Tablet dosing is 150mg QD or 150mg BID dosing based on severity of indications. - Tablet: 8 days for ABECs, pharyngitis, 10 days for AMS and CAP. - Incidence of GI side effects equal to clar (assuming comparable drug levels to tablet). - COGS target \$2,500/kg at launch for tablet. 	<ul style="list-style-type: none"> - ABT-773 is a potent ketolide with strong activity against most macrolide resistant strains, while maintaining the broad spectrum coverage of clarithromycin. - Product will be available as tablet and IV formulation. - ABT-773 will address the major unmet medical needs of increasing resistance to current ampicic agents, particularly S. pneumoniae. - Maintains clar's claim of "Spans the spectrum" (G+, G-, atypicals). - Cover key G+ resistant strains (S. pneumoniae, S. pyogenes). - Tablet dosing is 150mg QD or 150mg BID dosing based on severity of indications. - Tablet: 8 days for ABECs, pharyngitis, 10 days for AMS and CAP. - Incidence of GI side effects equal to clar (assuming comparable drug levels to tablet). - COGS target \$2,500/kg at launch for tablet. 	<ul style="list-style-type: none"> - ABT-773 is a potent ketolide with strong activity against most macrolide resistant strains, while maintaining the broad spectrum coverage of clarithromycin. - Product will be available as tablet and IV formulation. - ABT-773 will address the major unmet medical needs of increasing resistance to current ampicic agents, particularly S. pneumoniae. - Maintains clar's claim of "Spans the spectrum" (G+, G-, atypicals). - Cover key G+ resistant strains (S. pneumoniae, S. pyogenes). - Tablet dosing is 150mg QD or 150mg BID dosing based on severity of indications. - Tablet: 8 days for ABECs, pharyngitis, 10 days for AMS and CAP. - Incidence of GI side effects equal to clar (assuming comparable drug levels to tablet). - COGS target \$2,500/kg at launch for tablet. 	<ul style="list-style-type: none"> - ABT-773 is a potent ketolide with strong activity against most macrolide resistant strains, while maintaining the broad spectrum coverage of clarithromycin. - Product will be available as tablet and IV formulation. - ABT-773 will address the major unmet medical needs of increasing resistance to current ampicic agents, particularly S. pneumoniae. - Maintains clar's claim of "Spans the spectrum" (G+, G-, atypicals). - Cover key G+ resistant strains (S. pneumoniae, S. pyogenes). - Tablet dosing is 150mg QD or 150mg BID dosing based on severity of indications. - Tablet: 8 days for ABECs, pharyngitis, 10 days for AMS and CAP. - Incidence of GI side effects equal to clar (assuming comparable drug levels to tablet). - COGS target \$2,500/kg at launch for tablet.
Projected Spending by Year	74.1	91.5	69.0	45.0	333.6
Total	74.1	91.5	69.0	45.0	333.6

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Ketolide (ABT-773)																			
2001 Plan Development Cost Summary																			
Program Status		1999		2000		2001		2002		2003		2004							
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4		
Phase IIB (Tablet)																			
Phase III (Tablet)																			
		<div style="display: flex; justify-content: space-between;"><div>Tablet NDA Filing</div><div>Tablet Launch</div></div>																	
Major Development Activities and Costs																			
Clinical Program		Total Patients		Enrolled 9/29/00		Start		End		2000 AGU Cost		2001 Plan Cost							
Phase IIB Studies (3 Indications)		900		863		Sep-99		Jun-00		\$5,017		\$0							
Phase III (4 Indications)		5,440		0		Nov-00		May-02		\$10,885		\$41,051							
Japan Studies		TBD		0		Oct-00		Dec-01		\$1,723		\$4,000							
Pediatric PK/PD / Taste Testing Studies		24		42		Mar-00		Sep-00		\$575		\$0							
External Special Population Studies		36		117		Mar-00		Mar-01		\$1,686		\$83							
Internal BIC Studies (Phase I Center)		250		162		Jan-01		Dec-01		\$2,524		\$2,150							
Microbiology Grants		N/A		N/A		Jan-01		Dec-01		\$2,000		\$2,000							
Venture Management										\$5,438		\$8,863							
European Venture Research										\$1,133		\$1,474							
Data Management/Statistics										\$3,518		\$5,032							
										\$24,488		\$62,638							
Chemistry, Manufacturing, and Controls (CMC)																			
										2000 AGU		2001 Plan							
Formulation & Analytical										\$6,076		\$5,584							
Bulk Drug / Process										\$24,529		\$16,432							
										\$31,205		\$22,026							
Drug Safety Support																			
Ongoing Drug Safety support including: Long Term Toxicity Studies										2000 AGU		2001 Plan							
										\$3,374		\$1,749							
										\$3,374		\$1,749							
Other Support Costs																			
Discovery										2000 AGU		2001 Plan							
Regulatory Affairs / Research QA / Investigational Drug OA										\$2,886		\$2,418							
Medical Affairs										\$1,361		\$881							
Other										\$879		\$887							
Total Program										\$97		\$681							
										\$74,100		\$81,400							

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Endothelin (ABT-627)
Annual Development Plan
Exhibit 1.6

Therapeutic Area	Oncology																																									
Indications	<ul style="list-style-type: none">Hormone Refractory Prostate CancerPotential for use in early Prostate Cancer and other cancer typesABT-627 is Abbott's leading endothelin antagonist receptorABT-627 is seeking an indication for the treatment of hormone refractory prostate cancerABT-627 will probably be used with current therapiesWell tolerated as chronic therapyOral administrationNo major drug Interactions with drugs commonly used in elderly population or hormonal therapyDemonstrated cost effectiveness at filing																																									
Description																																										
Current Time Line	<table><tr><th>Milestones</th><th>Date</th></tr><tr><td>Phase I</td><td>2Q1996</td></tr><tr><td>Phase II</td><td>4Q1997</td></tr><tr><td>Phase III</td><td>4Q2000</td></tr><tr><td>NDA Filing</td><td>2Q2004</td></tr><tr><td>Launch</td><td>4Q2004</td></tr></table>		Milestones	Date	Phase I	2Q1996	Phase II	4Q1997	Phase III	4Q2000	NDA Filing	2Q2004	Launch	4Q2004			<table><tr><th>Spending</th><th>\$\$</th></tr><tr><td>Project-to-Date Spending (thru '00)</td><td>127.5</td></tr><tr><td>2001 Current Projection (Plan)</td><td>38.0*</td></tr></table>		Spending	\$\$	Project-to-Date Spending (thru '00)	127.5	2001 Current Projection (Plan)	38.0*																		
Milestones	Date																																									
Phase I	2Q1996																																									
Phase II	4Q1997																																									
Phase III	4Q2000																																									
NDA Filing	2Q2004																																									
Launch	4Q2004																																									
Spending	\$\$																																									
Project-to-Date Spending (thru '00)	127.5																																									
2001 Current Projection (Plan)	38.0*																																									
						* See page 2 for detail.																																				
Projected Spending by Year	<table><tr><th></th><th>2000</th><th>2001</th><th>2002</th><th>2003</th><th>2004</th><th>2005</th><th>Total</th></tr><tr><td>PC*</td><td>13.0</td><td>38.0</td><td>40.0</td><td>33.0</td><td>20.0</td><td>10.0</td><td>154.0</td></tr><tr><td>EPcA*</td><td>N/A</td><td>6.0</td><td>6.0</td><td>6.0</td><td>0.0</td><td>0.0</td><td>17.0</td></tr><tr><td>FE*</td><td>N/A</td><td>6.0</td><td>3.0</td><td>0.0</td><td>0.0</td><td>0.0</td><td>9.0</td></tr></table>											2000	2001	2002	2003	2004	2005	Total	PC*	13.0	38.0	40.0	33.0	20.0	10.0	154.0	EPcA*	N/A	6.0	6.0	6.0	0.0	0.0	17.0	FE*	N/A	6.0	3.0	0.0	0.0	0.0	9.0
	2000	2001	2002	2003	2004	2005	Total																																			
PC*	13.0	38.0	40.0	33.0	20.0	10.0	154.0																																			
EPcA*	N/A	6.0	6.0	6.0	0.0	0.0	17.0																																			
FE*	N/A	6.0	3.0	0.0	0.0	0.0	9.0																																			
* End of Phase II meeting with FDA just completed. Budget Impact still in process plus discussion of other cancer indications ongoing. 2001 range \$35-40 depending on outcome of discussion.																																										

* End of Phase II meeting with FDA just completed. Budget impact still in process plus discussion of other cancer indications ongoing. 2001 range \$35-40 depending on outcome of discussion.



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Endothelin (ABT-627)

CCM (ABT-594)
Annual Development Plan
Exhibit 1.6

Therapeutic Area	Neuroscience						
Indications	ABT-594 primary target indication is the treatment of neuropathic pain (NP).						
Description	- ABT-594 is a non-opioid, non-NSAID analgesic that is a potent and selective neuronal nicotinic receptor modulator.						
	- ABT-594 is effective in nociceptive pain and neuropathic pain.						
	- ABT-594 is expected to have a better side effect profile than opioids, no tolerance, no abuse, and no DEA scheduling.						
	- Pre clinical data show ABT-594 to be 30 to 100 times more potent and equally efficacious to morphine in treating moderate to severe pain in several well characterized animal models of pain.						
	- ABT-594 has a unique mechanism of action which may enable use in combination with other analgesics as well as monotherapy.						
Current Time Line	- Slow onset of action (approx. 1.5 - 3 hours) at low doses tested may suggest limited utility in acute pain types.						
	- Favorable safety profile.						
	- Oral formulation, BID dosing.						
Projected Spending by Year						Total	
	2000	2001	2002	2003	2004	2005	153.4
		14.4	35.0	45.0	32.0	15.0	12.0

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PROTEIN STATUS		2001 Plan Development Cost Summary																								
		1997		1998		1999		2000		2001		2002		2003		2004										
Phase I	Phase II	Phase III	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4								
																										
																										
Major Development Activities and Costs																										
Clinical Program																										
			Total Patients		Enrolled		Start		End		2000 AGU		2001 Plan													
					8/30/00						Cost		Cost													
			320		135		Apr-00		Nov-00		\$1,000		\$0													
		Phase IIb Neuropathic Pain	281		N/A		Feb-01		Sep-02		\$0		\$2,129													
		Phase I Studies	575		N/A		Jan-01		Nov-01		\$0		\$5,261													
		Phase IIb Osteoarthritis	3,400		N/A		Oct-01		May-04		\$0		\$6,370													
		Phase III Studies									\$4,493		\$5,137													
		Venture Management									\$210		\$5,042													
		Clinical Pharmacology Support (Phase I Center Studies)									\$0		\$105													
		EVR Support									\$646		\$2,197													
		Data Management/Statistics									\$8,349		\$26,241													
Chemistry, Manufacturing, and Controls (CMC)																										
		Packaging of Phase IIb clinical supplies and Phase III formulation development and pre-scale up									2000 AGU		2001 Plan													
											\$1,624		\$1,268													
		Formulation & Analytical									\$359		\$950													
		Bulk Drug / Process									\$285		\$1,202													
		Other									\$2,768		\$3,427													
											\$2,417		\$1,402													
Drug Safety Support																										
		Ongoing Drug Safety support including: Toxicity, carcinogenicity, and animal pharmacology studies									2000 AGU		2001 Plan													
		Clinical Program Support									\$350		\$154													
		Discovery									\$95		\$152													
		Medical Affairs									\$155		\$1,147													
		Regulatory Affairs / Research QA / Investigational Drug QA									\$552		\$482													
		Other																								
		Total Program									\$14,386		\$35,005													
Other Support Costs																										

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JH 008122

Quinolone (ABT-492)
Annual Development Plan
Exhibit 1.6

Therapeutic Area	Antibacterial	Spending					2001 Current Projection (Plan)	2001 Current Projection (Plan)												
Indications	<ul style="list-style-type: none">- Community acquired respiratory, nosocomial pneumonia, complicated and uncomplicated urinary tract and skin/soft tissue infections.- ABT-492 is a potent broad-spectrum quinolone with activity against Gram+, Gram-, and atypical pathogens, including most penicillin, macrolide, and quinolone resistant strains of S. pneumoniae.- Commercial objective is "Trovan-like" activity with "Levaquin-like" safety.- Preliminary in-vitro safety assays suggest good safety profile.- Product will be available in tablet and injectable formulations.- Targeting QD dosing for both formulations (not confirmed).- Targeting 5-7 day dosing for most indications (not confirmed).- COGS at \$1,500-3,200/kg at launch pending chemistry optimization.						11.3	25.0*												
Description																				
Current Time Line	<table><tr><th>Milestones</th><th>Date</th></tr><tr><td>Phase I</td><td>4Q2000</td></tr><tr><td>Phase II</td><td>3Q2001</td></tr><tr><td>Phase III</td><td>3Q2002</td></tr><tr><td>NDA Filing</td><td>4Q2004</td></tr><tr><td>Launch</td><td>4Q2005</td></tr></table>	Milestones	Date	Phase I	4Q2000	Phase II	3Q2001	Phase III	3Q2002	NDA Filing	4Q2004	Launch	4Q2005							
Milestones	Date																			
Phase I	4Q2000																			
Phase II	3Q2001																			
Phase III	3Q2002																			
NDA Filing	4Q2004																			
Launch	4Q2005																			
Projected Spending by Year		2000	2001	2002	2003	2004	2005	Total												
		6.8	25.0	75.0	100.0	52.0	11.0	269.8												

Quinolone (ABT-492)

2001 Plan Development Cost Summary

Program Status																
Phase I Phase II Phase III	2000		2001		2002		2003		2004		2005					
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Major Development Activities and Costs																
Clinical Program	Total Patients		Enrolled 8/31/2000		Start		End		2000 AGU Cost		2001 Plan Cost					
Phase I																
Single Rising Dose / Food Effects In Healthy Volunteers	116		0		Nov-00		Jan-01		\$500		\$170					
Multiple Rising Dose In Healthy Volunteers	60		0		Nov-00		Apr-01		\$500		\$300					
External PK Studies	N/A		0		Apr-01		Sep-01		\$0		\$900					
Microbiology Studies	N/A		N/A		Jan-01		Dec-01		\$0		\$713					
Phase IIA - AECB	250		0		Aug-01		Apr-02		\$0		\$2,083					
Phase IIB - CAP	250		0		Nov-01		Jul-02		\$201		\$833					
Venture Management									\$28		\$58					
European Venture Research									\$70		\$130					
Phase I Center									\$53		\$488					
Data Management/Statistics									\$1,352		\$6,886					
Chemistry, Manufacturing, and Controls (CMC)																
Bulk Drug / Process Formulation & Analytical									2000 AGU \$598		2001 Plan \$7,872					
									\$593		\$961					
									\$1,191		\$8,833					
Drug Safety Support	Ongoing Drug Safety support including: Toxicity Studies								2000 AGU \$1,841		2001 Plan \$2,331					
									\$1,841		\$2,331					
Other Support Costs	Discovery Reg. / Res. Quality Assurance / Investigational Drug QA Medical Affairs Other Milestone Payments (Initiation of Phase IIA)								2000 AGU \$3,224		2001 Plan \$834					
									\$110		\$35					
									\$0		\$47					
									\$0		\$3,000					
									\$2,316		\$8,840					
									\$6,800		\$25,000					
Total Program																

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TSP (ABT-510)
Annual Development Plan
Exhibit 1.6

Therapeutic Area		Oncology	
Indications		Solid tumors such as lung, breast, ovary, bladder and pancreas.	
Description	- Thrombospondin peptide		Spending
	- Novel anti-angiogenesis agent		
	- Parenteral dosing		
	- ABT-510 is seeking an indication for the treatment of solid tumors		
- Mechanism may prevent the growth of tumors and prevent the spread of metastases by preventing or inhibiting the growth of nutrient supplying blood vessels		Project-to-Date-Spending (thru '00)	
		2001 Current Projection (Plan)	
		* See page 2 for detail.	
		45.6	
		9.0*	
Current Time Line		Milestones	Date
		DDC	4Q1998
		Phase I	2Q2000
		Phase II	4Q2001
		Phase III	1Q2003
		NDA Filing	1Q2005
		Launch	1Q2006
Projected Spending by Year		2000	2001
		6.6	9.0
		2002	2003
		37.0	29.0
		2004	2005
		23.0	15.0
		Total	119.6

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**TSP (ABT-510)
2001 Plan Development Cost Summary**

[illegible]

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MMPI (ABT-518)
Annual Development Plan
Exhibit 1.6

Therapeutic Area		Oncology													
Indications		Solid tumors such as lung, ovarian, pancreas, breast, colorectal and bladder.													
Description		<ul style="list-style-type: none">- Novel metalloproteinase inhibitor.- Cytostatic mechanism.- Oral dosing.- May prevent the growth of metastatic lesions and/or inhibit primary tumor growth.- Superior efficacy or side-effect profile to competitive agents.													
		Current Time Line		Milestones		Date		Spending							
		DDC		Phase I		1Q2001		Project-to-Data-Spending (thru '00)							
		Phase II		3Q2002				40.0							
		Phase III		4Q2003				7.0*							
		NDA Filing		4Q2005											
		Launch		2Q2006				* See page 2 for detail.							
Projected Spending by Year		2000		2001		2002		2003		2004		2005		Total	
		5.0		7.0		31.0		35.0		26.0		20.0		124.0	

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Anti-Mitotic (ABT-751)
Annual Development Plan
Exhibit 1.6

Therapeutic Area		Oncology	
Indications		Solid tumors such as breast, lung, colorectal, and ovarian	
Description		<ul style="list-style-type: none"> - Novel oral cytotoxic agent that inhibits tumor growth by inhibiting the polymerization of tubulin, similar to the MOA of taxanes - May be effective in patients resistant to other cytotoxic agents 	
Current Time Line	Milestones	Date	Spending Project-to-Date-Spending (thru '00) 2001 Current Projection (PLAN) * See page 2 for detail.
	In-License	2Q/2000	
Projected Spending by Year	Phase I	1Q/2001	\$5 6.0 10.0*
	Phase II	4Q/2001	
	Phase III	4Q/2002	
	NDA Filing	1Q/2005	
Projected Spending by Year	Launch	1Q/2006	2000 8.0
Total		2001	10.0
Total		2002	27.0
Total		2003	35.0
Total		2004	25.0
Total		2005	12.0
Total		Total	116.0

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Anti-Mitotic (ABT-751)

[illegible]

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FTI (ABT-xxx)
Annual Development Plan
Exhibit 1.6

Therapeutic Area Indications	Oncology						
	Solid tumors such as lung, breast, ovary, bladder and pancreas. - Farnesyltransferase Inhibitor. - Mechanism of action is unknown, but thought to inhibit farnesylated proteins which are integral for malignant tumor growth.						
Description	Milestones		Date	Spending	Project-to-Date-Spending (thru '00) 2001 Current Projection (Plan) * See page 2 for detail.		
	Current Time Line						
	DOC	Phase I	1Q/2001		35.0		
		Phase II	2Q/2003		6.0*		
		Phase III	3Q/2004				
		NDA Filing	4Q/2006				
		Launch	4Q/2007				
Projected Spending by Year	2000	2001	2002	2003	2004	2005	Total
	N/A	8.0	15.0	30.0	30.0	18.0	99.0

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Pharmaceutical Products Division
Sample Direct/Indirect Project Funding Distribution
2001 Plan (\$000)

	ADT - 773 (Late Stage - Phase III)			MMPI (Early Stage)		
	Direct	Indirect	Total	Direct	Indirect	Total
PPD Investigational Drug	0.3	0.0	0.4	-	-	-
Venture Management	4.8	1.6	6.5	0.8	0.2	0.9
Discovery	2.2	0.2	2.4	1.1	0.3	1.3
Drug Safety	1.6	0.2	1.7	1.8	0.3	2.1
PARC	4.8	0.4	5.3	0.8	0.2	1.0
Phase I Center	2.0	0.1	2.1	0.1	0.0	0.1
Development Operations	4.2	0.5	4.6	0.1	0.0	0.1
Regulatory Affairs	0.2	0.0	0.3	0.0	0.0	0.0
Medical Affairs	0.8	0.1	0.9	0.0	0.0	0.0
Administration	1.6	-	1.6	0.1	-	0.1
All Manpower	0.7	-	0.7	-	-	-
Bulk Drug / Process	15.0	-	15.0	-	-	-
Clinical Grants	43.1	-	43.1	1.3	-	1.3
Total	81.4	3.2	84.6	6.2	0.9	7.1
% Split	96.2%	3.8%	100.0%	86.6%	13.4%	100.0%

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Pharmaceutical Products Division
Sample Direct/Indirect Rate & Headcount Distribution
2001 Plan

<u>Rate:</u>	<u>Data Management</u>	<u>Toxicology/Pathology</u>
Direct		
Payroll (Both PMP and Supv/Mgr)	6,577	5,277
Office Supplies	53	51
T & E	26	84
Sem/Edu	21	73
Supplies	41	440
Consultant	291	67
Printing	73	4
Clinical Tracking Costs	4,075	---
Depreciation	1,031	258
UNIX Based Support	3,453	921
Utilities	62	---
Floorspace	579	1,479
Housekeeping	23	---
Other	112	389
Sub-Total Direct	16,416	9,042
Indirect		
Patents & Trademarks	285	388
Corporate Indirect	697	949
PPD Indirect (Mgmt.)	337	458
Department Overhead	396	584
Other	46	62
Sub-Total Indirect	1,761	2,441
Total	18,177	11,483
% Direct	90%	79%
% Indirect	10%	21%
<u>Headcount:</u>		
Direct Headcount	123	53
Indirect Headcount	17	7
Total Headcount	140	60
Rate	92.06	135.42
Hours	1,600	1,600
Annual Rate	147,296	216,672

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EXHIBIT 1.17

EISAI TERRITORY

1. Bhutan
2. Brunei
3. Cambodia
4. People's Republic of China
5. Republic of China (Taiwan)
6. India
7. Indonesia
8. Japan
9. Democratic People's Republic of Korea (North Korea)
10. Republic of Korea
11. Laos
12. Macao
13. Malaysia
14. Mongolia
15. Myanmar
16. Nepal
17. Pakistan
18. Papua New Guinea
19. Philippines
20. Singapore
21. Sri Lanka
22. Thailand
23. Vietnam
24. Italy, co-exclusive rights with Abbott, unless Abbott exercises its rights under the terms of the Eisai Agreement to take an exclusive right to Italy.

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EXHIBIT 1.40

PROGRAM COMPOUNDS

<u>In-License Agreement</u>	<u>Program Compound</u>	<u>Development Phase</u>
Taisho	ABT-627 (Endothelin antagonist)	phase III
	ABT-773 (Ketolide antibiotic)	phase III
	ABT-594 (Cholinergic channel modulator)	late phase II
Wakunaga	ABT-492 (Quinolone antibiotic)	phase I
Eisai	ABT-751 (Antimitotic)	phase I
	ABT-510 (Thrombospondin peptide)	phase I
<u>Preclinical Programs:</u>		
FTI Program		late preclinical
ED Program		late preclinical
MMPI Program	ABT-518 (Matrix metalloproteinase inhibitor)	phase I

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EXHIBIT 1.43

EXAMPLE OF PROGRAM RELATED COSTS FOR ONE PROGRAM COMPOUND

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2001 KEY RATES									
	2000			2001			% Change		
	Rate	Hours	Annual Rate	Rate	Hours	Annual Rate	Hourly Rate	Total Hours	Annual Rate
DRUG SAFETY									
Toxicology/Pathology - PMP/TMP	121.52	1,680	204,154	135.42	1,600	216,672	11.4%	4.8%	6.1%
Metabolism/Microscopy - PMP/TMP	144.75	1,600	231,600	141.64	1,650	233,706	-2.1%	3.1%	0.9%
Comparative Medicine - PMP/TMP	115.60	1,768	204,381	116.88	1,850	216,228	1.1%	4.6%	5.8%
Strategic & Exploratory - PMP/TMP	121.52	1,680	204,154	173.56	1,600	277,696	42.8%	4.8%	36.0%
PHASE I CENTER									
Pharmacokinetics 4PK - PMP/TMP	144.75	1,600	231,600	135.00	1,600	216,000	-6.7%	...	-6.7%
Clin. Res. MDs 42P - PMP	...	...	...	180.35	1,500	270,525	...	...	...
Clin Res. Spec. 420-PMP/TMP	113.59	1,700	193,103	123.75	1,700	210,375	8.9%	...	8.9%
PARD									
Prod Dev - PMP, TMP	108.54	1,800	195,372	116.71	1,800	210,078	7.5%	...	7.5%
IDS - PMP, TMP	160.80	1,600	257,280	162.11	1,600	259,376	0.8%	...	0.8%
DEV OPERATIONS									
Data Mgmt D433 - TMP/PMP	90.04	1,600	144,064	92.06	1,600	147,296	2.2%	...	2.2%
Stats - PMP/TMP	97.75	1,800	175,950	99.10	1,800	178,380	1.4%	...	1.4%
RA/QA									
RA/QA - PMP & TMP	125.50	1,600	200,800	134.48	1,600	215,184	7.2%	...	7.2%
DISCOVERY									
	137.65	1,800	247,770	142.91	1,800	257,238	3.8%	...	3.8%

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03/13/01 02:09:34 PM

2001 KEY RATES 201 123

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EXHIBIT 9.2

PAYMENT INSTRUCTIONS

Fleet Boston
ABA No. 011000390
Boston, Massachusetts 02110
Account of: John Hancock Life Insurance Co. Private Placement Collection Acct.
Account Number: 541-55417
On Order of: Abbott Laboratories -- Research Funding Agreement dated as of March 13, 2001

E-3233160

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Exhibit 12.2(d)

Further Information Regarding Program Compounds

COMPOUND	CHEMICAL NAME	CURRENT STAGE OF DEVELOPMENT
ABT-627 Endothelin antagonist	(2R,3R,4S)-4-(1,3-benzodioxol-5-yl)-1-[2-(dibutylamino)-2-oxoethyl]-2-(4-methoxyphenyl)-3-pyrrolidinecarboxylic acid	Phase III
ABT-773 Ketolide antibiotic	(3aS,4R,7R,9R,10R,11S,13R,15R,15aR)-4-ethyl-3a,7,9,11,13,15-hexamethyl-2,6,8,14-tetraoxo-11-[[[(2E)-3-(3-quinolinyl)-2-propenyl]oxy]tetradecahydro-2H-oxacyclotetradecino[4,3-d][1,3]oxazol-10-yl 3,4,6-trideoxy-3-(dimethylamino)-D-xyllo-hexopyranoside	Phase III
ABT-594 Cholinergic channel modulator	(2R)-azetidinylmethyl 6-chloro-3-pyridinyl ether hydrochloride	Phase II
ABT-492 Quinoline Antibiotic	potassium 1-(6-amino-3,5-difluoro-2-pyridinyl)-8-chloro-6-fluoro-7-(3-hydroxy-1-azetidinyl)-4-oxo-1,4-dihydro-3-quinolinecarboxylate	Phase I
ABT-518 Matrix metalloproteinase inhibitor	(1S)-1-[(4S)-2,2-dimethyl-1,3-dioxolan-4-yl]-2-[(4-{4-(trifluoromethoxy)phenoxy}phenyl)sulfonyl]ethyl(hydroxy)formamide	Phase I
ABT-751 Antimitotic	N-[2-(4-hydroxyanilino)-3-pyridinyl]-4-methoxybenzenesulfonamide	Phase I
Farnesyltransferase inhibitor	N.A.	Pre-Clinical Program
Dopamine Receptor Agonist for Erectile Dysfunction	N.A.	Pre-Clinical Program

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EXHIBIT 12.2(e)

Certain Patent Information

ABT-627

COUNTRY	FILING DATE	PATENT NUMBER	STATUS	EXP. DATE
Australia	08/04/1995	711832	<i>Issued</i>	08/04/2015
Brazil	02/12/1997		<i>Pending</i>	
Canada	08/04/1995		<i>Pending</i>	
EP*	08/04/1995		<i>Pending</i>	
Hong Kong	07/15/1998		<i>Pending</i>	
Israel	08/10/1995		<i>Pending</i>	
Japan	08/04/1995		<i>Pending</i>	
Korea	08/04/1995		<i>Pending</i>	
Mexico	08/04/1995		<i>Pending</i>	
Philippines	08/17/1995		<i>Pending</i>	
USA	05/30/1995	5,767,144	<i>Issued</i>	06/16/2015

*Europe: Austria, Belgium, Great Britain, Denmark, France, Germany, Greece, Ireland, Italy, Luxembourg, Netherlands, Portugal, Spain, Sweden, Switzerland

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Exhibit 12.2(e) (Cont'd)

ABT-773
(Subject to Taisho Agreement)

COUNTRY	FILING DATE	PATENT NUMBER	STATUS	EXP. DATE
Argentina	09/03/1997		Pending	
Australia	09/02/1997		Pending	
Brazil	05/13/1997		Pending	
Brazil	09/02/1997		Pending	
Bulgaria	09/02/1997		Pending	
Belarus	09/02/1997		Pending	
China	09/02/1997		Pending	
Chile	09/04/1997		Pending	
Canada	09/02/1997		Pending	
Columbia	09/02/1997		Pending	
Czech Republic	09/02/1997		Pending	
EP*	09/02/1997		Pending	
Guatemala	08/29/1997		Pending	
Hong Kong	09/02/1997		Pending	
Croatia	09/03/1997		Pending	
Hungary	09/02/1997		Pending	
Indonesia	09/04/1997		Pending	
India	Pending-Black Box		Pending	
Israel	09/02/1997		Pending	
Japan	09/02/1997		Pending	
Korea	09/02/1997		Pending	
Mexico	09/02/1997		Pending	
Malaysia	08/26/1997		Pending	
Norway	09/02/1997		Pending	

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Exhibit 12.2(e) (cont'd)

ABT-773 (cont'd)
(Subject to Taisho Agreement)

COUNTRY	FILING DATE	PATENT NUMBER	STATUS	EXP. DATE
New Zealand	09/02/1997		Pending	
Philippines	09/02/1997		Pending	
Pakistan	10/13/1997	136010	Issued	10/13/2013
Poland	09/02/1997		Pending	
Romania	09/02/1997		Pending	
Russia	09/02/1997		Pending	
South Africa	08/20/1997	97/7474	Issued	08/20/2017
Singapore	09/02/1997		Pending	
Slovak Republic	09/02/1997		Pending	
Slovenia	09/02/1997	20023	Issued	09/02/2017
Saudi Arabia	02/10/1998		Pending	
Thailand	09/03/1997		Pending	
Turkey	09/02/1997	TR 01127 B	Issued	09/02/2017
Taiwan	09/05/1997		Pending	
UA	09/02/1997		Pending	
USA	07/03/1997	5,866,549	Issued	09/04/2016
Yugoslavia	09/02/1997		Pending	

*Europe: Austria, Belgium, Great Britain, Denmark, France, Germany, Greece, Ireland, Italy, Luxembourg, Netherlands, Portugal, Spain, Sweden, Switzerland

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EXHIBIT 12.2(e) (Cont'd)

ABT-594

COUNTRY	FILING DATE	PATENT NUMBER	STATUS	EXP. DATE
Australia	10/08/1993	687017	Issued	10/18/2013
Brazil	04/30/1997		Pending	
Canada	10/08/1993		Pending	
EP*	10/08/1993		Pending	
Hong Kong	12/10/1998		Pending	
Israel	10/04/1993	107184	Issued	10/04/2013
Japan	10/08/1993	3098035	Issued	10/08/2013
Korea	10/08/1993		Pending	
Mexico	10/08/1993		Pending	
Philippines	10/07/1993		Pending	
USA	06/07/1995	5,948,793	Issued	09/07/2016

*Europe: Austria, Belgium, Great Britain, Denmark, France, Germany, Greece, Ireland, Italy, Luxembourg, Netherlands, Portugal, Spain, Sweden, Switzerland

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EXHIBIT 12.2(e) (Cont'd)

ABT-492

(Subject to Wakunaga Agreement)

COUNTRY	FILING DATE	PATENT NUMBER	STATUS	EXP. DATE
Australia	09/24/1999		Pending	
Brazil	11/29/1999		Pending	
Canada	12/06/1999		Pending	
China	10/22/1999	1258674A	Issued	
Hong Kong				
EP*	12/08/1999	0992501	Issued	
Hungary	11/23/1999	9904389	Issued	
Republic of Korea	08/29/2000			
Mexico	10/14/1999		Pending	
Russian Federation	05/26/2000		Pending	
USA	06/10/1999		Pending	
Japan	10/06/1999	2000-136191	Issued	

*Europe: Austria, Belgium, Switzerland, Germany, Denmark, Spain, Finland, France, Great Britain, Greece, Ireland, Italy, Luxembourg, Monaco, Netherlands, Portugal, Sweden

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EXHIBIT 12.2(e) (Cont'd)

ABT-510

COUNTRY	FILING DATE	PATENT NUMBER	STATUS	EXP. DATE
Argentina	05/21/1999		Pending	
Australia	05/21/1999		Filing in Process	
Brazil	05/21/1999		Filing in Process	
Bulgaria	05/21/1999		Filing in Process	
China	05/21/1999		Filing in Process	
Chile	05/20/1999		Pending	
Canada	05/21/1999		Filing in Process	
Columbia	05/21/1999		Pending	
Czech Republic	05/21/1999		Filing in Process	
EP*	05/21/1999		Filing in Process	
Hong Kong	05/21/1999		Filing in Process	
Hungary	05/21/1999		Pending	
India	05/21/1999		Filing in Process	
Israel	05/21/1999		Filing in Process	
Japan	05/21/1999		Filing in Process	
Korea	05/21/1999		Filing in Process	
Mexico	05/21/1999		Filing in Process	
Norway	05/21/1999		Filing in Process	
New Zealand	05/21/1999		Filing in Process	
Philippines	05/21/1999		Pending	
Poland	05/21/1999		Filing in Process	
South Africa	05/21/1999		Filing in Process	
Slovak Republic	05/21/1999		Filing in Process	
Saudi Arabia	05/21/1999		Pending	
Turkey	05/21/1999		Filing in Process	
Taiwan	05/21/1999		Pending	
USA	05/21/1999		Pending	

*Europe: Austria, Belgium, Great Britain, Cyprus, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, Netherlands, Portugal, Romania, Slovenia, Spain, Sweden, Switzerland

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EXHIBIT 12.2(e) (Cont'd)

ABT-518

COUNTRY	FILING DATE	PATENT NUMBER	STATUS	EXP. DATE
Argentina	07/30/1998		Pending	
Australia	07/27/1998		Pending	
Brazil	07/27/1998		Pending	
Bulgaria	07/27/1998		Pending	
China	07/27/1998		Pending	
Chile	07/17/1998		Pending	
Canada	07/27/1998		Pending	
Columbia	07/29/1998		Pending	
Czech Republic	07/27/1998		Pending	
EP*	07/27/1998		Pending	
Hungary	07/27/1998		Pending	
Israel	07/27/1998		Pending	
Japan	07/27/1998		Pending	
Korea	07/27/1998		Pending	
Mexico	07/27/1998		Pending	
Norway	07/27/1998		Pending	
New Zealand	07/27/1998		Pending	
Philippines	07/27/1998		Pending	
Poland	07/27/1998		Pending	
South Africa	07/30/1998	98/6828	Issued	07/30/2018
Slovak Republic	07/27/1998		Pending	
Saudi Arabia	12/15/1998		Pending	
Turkey	07/27/1998		Pending	
Taiwan	07/31/1998		Pending	
USA	08/05/1998		Pending	

*Europe: Austria, Belgium, Great Britain, Denmark, France, Germany, Greece, Ireland, Italy, Luxembourg, Netherlands, Portugal, Spain, Sweden, Switzerland

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EXHIBIT 12.2(e) (Cont'd)

ABT-751
(Subject to Eisai Agreement)

COUNTRY	FILING DATE	PATENT NUMBER	STATUS	EXP. DATE
USA	08/08/1991	5,250,549	Issued	08/08/2011
		5,292,758		08/08/2011
Germany	08/07/1991	EP 472,053	Issued	08/07/2011
United Kingdom	08/07/1991	EP 472,053	Issued	08/07/2011
France	08/07/1991	EP 472,053	Issued	08/07/2011

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EXHIBIT 12.2(f)

COMMUNICATIONS

With respect to ABT-594, Abbott has received the following communications:

- * Correspondence from Sibia Neurosciences, 505 Coast Blvd. South, Suite 300, La Jolla, CA 92037 (Sibia was acquired by Merck & Co., Inc. in August, 1999) including, most recently, a letter dated March 13, 1998.
- * Correspondence from ICT Pharmaceuticals c/o Stadheim and Gear, Ltd., 400 North Michigan Ave., Chicago, IL 60611 including, most recently, a letter dated September 14, 2000.

The Sibia and ICT correspondence each refer to their patents on research tools.

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EXHIBIT 12.2(i)

Compound Reports

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JH 008152

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ABT – 773

Descriptive Memorandum

February 2001

Abbott Laboratories

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ABT-773

Opportunity Overview

ABT-773 pertains to a promising new class of antibiotics known as ketolides. ABT-773 is likely to have activity against resistant strains of bacteria and will, therefore, compete effectively against currently marketed antibiotics. The compound is currently in Phase II/III trials. Phase III clinical trials began in Q4, 2000. ABT-773 has an expected U.S. launch date in Q1, 2004. Ex-U.S. launches are projected in 2004 for Europe and Japan.

Product features such as high efficacy, activity against resistant strains of bacteria and convenience should enable it to compete against both Zithromax and newer agents such as the quinolones. Dosing is expected to be once-a-day. A 5-day convenience pak at a competitive price will help maximize sales.

The US Market

The overall antibiotic market in the U.S. reached \$8.9 billion in sales in 1999. The tab/cap segment is the largest; sales in 1999 were \$5.7 billion. The I.V. and oral suspension segments are comparatively smaller; total sales topped \$2.1 and \$1.1 billion, respectively.

Tab/cap and oral suspension prescription volume had been declining 1-2% per year in the period of 1995-1998, due to more appropriate prescribing in the face of increasing resistance. However, total tab/cap prescription volume recovered in 1999 and grew 6.3%. Even in the face of negative pressure on antibiotic use, dollar sales in the U.S. have continued to increase, particularly in the tab/cap market. This is due to the trend of replacing relatively low-cost generic agents with higher priced premium antibiotics. The market is willing to bear higher costs for agents that satisfy unmet needs. The I.V. market has grown slightly in terms of sales, also being driven largely by the replacement of generic agents with more costly branded agents.

Macrolides, largely fueled by the gains of Zithromax, have seen significant growth in terms of both prescriptions and sales. Zithromax prescriptions far outnumber those of other competitors, while its sales have nearly surpassed those of the sales leader, Cipro. Historically, quinolones saw relatively limited use for community respiratory tract infections (RTIs) because of poor Gram-positive coverage and sub-optimal adverse event profiles. Newer quinolones such as Levaquin have been successful in achieving more widespread use by virtue of its improved activity and adverse event profile. Levaquin currently accounts for approximately 30% of the quinolone market share. It is anticipated that recent quinolone introductions (Avelox, Tequin) will build upon the RTI momentum established by Levaquin. The growth of the macrolide and quinolone classes has come largely at the expense of cephalosporins and generic agents such as erythromycin and penicillin.

The following table shows 1999 tab/cap sales and prescriptions by class/product:

	Sales			TRXs		
	Sales (\$MM)	Share	CAGR ₉₅₋₉₉	TRXs (MM)	Share	CAGR ₉₅₋₉₉
Penicillins	\$148.3	2.6%	-1.0%	52.5	23.7%	-5.6%
Cephalosporins	\$980.9	17.2%	-5.8%	37.9	17.1%	-3.5%
Cefitin	\$363.9	6.7%	1.8%	5.0	2.3%	-1.0%
Cefzil	\$188.7	3.3%	12.5%	2.7	1.2%	11.3%
Other	\$408.3	7.1%	-14.7%	30.1	13.6%	-4.8%
Ext. Spec. Macrolides	\$1,595.6	27.9%	19.9%	36.1	16.3%	20.8%
Biaxin	\$890.5	12.1%	6.1%	11.3	5.1%	1.2%
Zithromax	\$891.1	15.8%	42.1%	24.4	11.0%	41.5%
Other	\$14.0	0.2%	21.0%	0.4	0.2%	53.0%
Quinolones	\$1,622.1	28.4%	17.0%	24.0	10.8%	11.7%
Cipro	\$902.5	15.8%	8.3%	14.1	6.4%	5.1%
Levaquin	\$529.4	9.3%	NA	7.0	3.1%	NA
Other	\$190.2	3.3%	-2.2%	3.0	1.3%	-6.4%
Augmentin	\$778.1	13.6%	17.8%	10.7	4.8%	11.8%
Other Classes	\$590.5	10.3%	-1.1%	60.4	27.3%	-4.1%
TOTAL TAB/CAP	\$5,715.4	100.0%	8.9%	221.6	100.0%	0.1%

U.S. Market Projections

Resistance to antibiotics is likely to increase, creating opportunities for new agents with activity against resistance. Physicians will be urged to choose agents with an appropriate spectrum of activity relative to the infection being treated. Resistance will increasingly become part of the promotional mix for emerging agents. The ability of an agent to treat resistant strains and the real or perceived ability to slow or prevent resistance development (mutation prevention concentration, low mutation frequency, structure-activity relationships, etc) may confer competitive advantage to such agents.

- Quinolones, which historically have seen limited use in community-acquired respiratory infections, will become a significant class in this segment as new agents from this class are launched that specifically target RTIs.
- The market will become more competitive as new agents enter both the community segment (ketolides, quinolones) as well as the nosocomial segment (oxazolidinones, streptogramins, evernimomycins, peptides, others).
- Several key branded antibiotics will lose patent exclusivity over the next three to five years.. This may create an opportunity in the pediatric market as the top three pediatric brands (Augmentin, Cefzil, Zithromax) are among those losing patent exclusivity.

Antiviral influenza and cold therapeutics, as well as an increasing number of antibacterial vaccines may have a negative impact on antibiotic prescriptions.

The Ex-U.S. Market

Ex-U.S. sales of antibiotics totaled \$11.7 billion in 1999. Tab/cap represents the largest segment, with sales of \$9.4 billion from 770 million total prescriptions. Total Rx growth has been flat, with a 1996-99 CAGR of 0.5%. The use of antibiotics is predicted to slowly decline due to more judicious use of antibacterials in the face of increasing bacterial resistance.

Ex-U.S., the quinolone class accounted for 8% of total tab/cap market prescriptions (62 million Rx's) and 13% of sales (\$1.2 billion). Ciprofloxacin is the market leader ex-U.S. with approximately 47% of the quinolone market Rx's (29 million Rx's) and 44% (\$530MM) of sales. Levofloxacin launched in many European markets in 1998/1999 and holds approximately 14% Rx share of the European quinolone market and 0.8% of the overall tab/cap market. Although grepafloxacin and trovafloxacin also launched in some European countries in 1999, both products were recently pulled from the market due to liver toxicity and other complications. Moxifloxacin launched in Germany in Q4 1999, but has not yet been approved in other markets. In Japan, levofloxacin launched in 1994 and still commands a 65% Rx share of the quinolone market and 10% of the Japanese tab/cap market overall. Japan accounts for approximately 80% of ex-U.S. levofloxacin sales (\$370MM).

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Scientific Rationale for ABT-773

The likely profile of ABT-773 justifies further development:

- ABT-773 pertains to a new class of antibiotics.
- Good activity against resistant Gram + organisms, particularly macrolide-resistant *S. pneumoniae*.
- Convenience, safety, and tolerability profile competitive with Z-pak.
- Oral Suspension and I.V. forms enabling penetration into pediatrics and hospital segments.

Clinical Studies

The safety and efficacy of ABT-773 in AECB were studied in a multi-center Phase II clinical trial conducted between January and April of 1999. Dosing regimens of 100mg TID and 200mg TID were tested. Of the 169 enrolled patients, 159 were clinically evaluable and 96 were both clinically and bacteriologically evaluable. The following chart summarizes the results.

Bacterial Eradication	ABT-773 100mg TID	ABT-773 200mg TID	Overall Eradication
<i>S. pneumoniae</i>	100% (13/13)	90% (9/10)	96% (22/23)
<i>M. catarrhalis</i>	100% (6/6)	100% (7/7)	100% (13/13)
<i>H. influenzae</i>	96% (23/24)	92% (24/26)	92% (47/50)
<i>H. parainfluenzae</i>	100% (6/6)	88% (7/8)	93% (13/14)

Clinical Response	ABT-773 100mg TID	ABT-773 200mg TID
Cure	96% (77/80)	92% (73/79)
Failure	4% (3/80)	8% (6/79)

Clinical and Bacterial Response	ABT-773 100mg TID	ABT-773 200mg TID
Cure	96% (46/48)	94% (45/48)
Failure	4% (2/48)	6% (3/48)

Adverse Events	ABT-773 100mg TID	ABT-773 200mg TID	Overall
Taste Perversion	5% (4/84)	8% (7/85)	6.5% (11/169)
Diarrhea	11% (9/84)	6% (5/85)	8% (14/169)
Nausea	2% (2/84)	2% (2/85)	2% (4/169)
Abdominal Pain	1% (1/84)	2% (2/85)	2% (3/169)
Headache	2% (2/84)	1% (1/85)	2% (3/169)
Rash	2% (2/84)	1% (1/85)	2% (3/169)
Dyspnea	2% (2/84)		1% (2/169)
Elev. Liver Funct. Test	1% (1/84)	1% (1/85)	1% (2/169)
Fever		2% (2/85)	1% (2/169)

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The safety and efficacy of ABT-773 in AECB were studied in a multi-center Phase IIb clinical trial from October 1999 to March 2000. Doses of 150mg QD, 300mg QD, and 600mg QD were tested. Of the enrolled subjects, 342 were clinically evaluable, and 169 were both clinically and bacteriologically evaluable. The following chart summarizes the results.

Bacterial Eradication	ABT-773 150mg QD	ABT-773 300mg QD	ABT-773 600mg QD	Overall Eradication
<i>S.pneumoniae</i>	83% (10/12)	90% (9/10)	100% (13/13)	91% (32/35)
<i>M.catarrhalis</i>	80% (8/10)	92% (12/13)	91% (10/11)	88% (30/34)
<i>H. influenzae</i>	94% (17/16)	89% (17/19)	83% (19/23)	88% (53/60)
Clinical Response				
Cure	87% (98/113)	90% (105/117)	90% (101/112)	
Failure	13% (15/113)	10% (12/117)	10% (11/112)	
Clinical & Bacteriological Response				
Cure	84% (42/50)	88% (49/56)	94% (59/63)	
Failure	16% (8/50)	12% (7/56)	6% (4/63)	
Adverse Events				
Taste Perversion	5% (4/84)	19% (25/129)	29% (37/129)	17% (66/384)
Diarrhea	13% (16/126)	12% (15/129)	21% (27/129)	15% (58/384)
Nausea	7% (9/126)	13% (17/129)	30% (38/129)	17% (64/384)
Vomiting	2% (3/126)	3% (4/129)	11% (14/129)	5% (21/384)
Nausea & Vomiting	0 (0/126)	<1% (1/129)	4% (5/129)	2% (6/384)
Abdominal Pain	4% (5/126)	4% (5/129)	4% (5/129)	4% (15/384)

The safety and efficacy of ABT-773 in Acute Bacterial Sinusitis (ABS) were studied in a multi-center Phase IIb clinical trial conducted from October 1999 to March 2000. Dosing regimens of 150mg QD, 300mg QD, and 600mg QD were tested. Of the 292 enrolled subjects, 246 were clinically evaluable. The following chart summarizes the results.

Bacterial Eradication	ABT-773 150mg QD	AB T-773 300mg QD	ABT-773 600mg QD	Overall Eradication
<i>S.pneumonia</i>	3/3	8/8	9/12	20/23
<i>M. catarrhalis</i>	8/9	3/4	4/4	15/17
<i>H. influenzae</i>	3/5	7/7	5/7	15/19
<i>S.aureus</i>	1/1	1/1	3/4	5/6
Clinical Response				
Cure	89% (70/79)	83% (70/84)	71% (59/83)	
Failure	11% (9/79)	17% (14/84)	29% (24/83)	
Adverse Events				
Taste Perversion	1% (16/97)	14% (14/98)	27% (26/97)	14% (41/292)
Diarrhea	6% (6/97)	6% (6/98)	17% (16/97)	10% (28/292)
Nausea	3% (3/97)	12% (12/98)	26% (25/97)	14% (40/292)
Vomiting	1% (1/97)	6% (6/98)	17% (16/97)	8% (23/292)

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The safety and efficacy of ABT-773 in community-acquired pneumonia (CAP) were studied in a multi-center Phase IIB clinical trial from October 1999 to March 2000. Dosing regimens of 300mg QD and 600mg QD were tested. Of the 187 enrolled subjects, 1248 were clinically evaluable, and 15 were both clinically and bacteriologically evaluable. The following chart summarizes the results.

Bacterial Eradication	ABT-773 300mg QD		ABT-773 600mg QD		Overall Eradication	
<i>S. pneumoniae</i>	87%	(13/15)	100%	(7/7)	91%	(20/22)
<i>M. catarrhalis</i>	75%	(6/8)	50%	(2/4)	67%	(8/12)
<i>H. influenzae</i>	100%	(9/9)	72%	(13/18)	81%	(22/27)
<i>M. pneumoniae</i>	93%	(13/14)	93%	(14/15)	93%	(27/29)
<i>C. pneumoniae</i>	95%	(19/20)	79%	(19/24)	86%	(38/144)
<i>L. pneumoniae</i>	100%	(3/3)	100%	(2/2)	100%	(5/5)
Clinical Response						
Cure	92%	(72/78)	80%	(56/70)		
Failure	8%	(6/78)	20%	(14/70)		
Clinical & Bacterial Response						
Cure	92%	(54/59)	82%	(47/57)		
Failure	8%	(5/59)	18%	(10/57)		
Adverse Events						
Taste Perversion	17%	(16/95)	26%	(24/92)	21%	(40/187)
Diarrhea	14%	(13/95)	19%	(17/92)	16%	(30/187)
Nausea	12%	(11/95)	22%	(20/92)	17%	(31/187)
V omitting	10%	(9/95)	15%	(14/92)	12%	(23/187)

• Appendix 1

Key Emerging Competitors

Generic	Brand	Company	Class	Status
moxifloxacin	Avelox	Bayer	Quinolone	Approved by FDA 12/13/00
gatifloxacin	Tequin	BMS	Quinolone	Approved by FDA 12/21/00
gemifloxacin	Factive	SKB	Quinolone	Filed NDA 12/15
T-3811	TBD	BMS/Toyama	Quinolone	Phase I
telithromycin	Ketek	Aventis	Ketolide	Filed NDA 3/00
linezolid	Zyvox	Pharmacia	Oxazolidinone	Approved by FDA Q2 '00

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ABT – 627

Descriptive Memorandum

February 2001

Abbott Laboratories

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Deposition Exhibit 1

P's Exhibit 32

Part 3

ABT-627

Opportunity Overview

ABT-627 is an orally bioavailable endothelin antagonist with a high selectivity for the Eta receptor. The endothelins (ET-1, ET-2, ET-3) are a family of 21 amino acid peptides first identified in 1988. Endothelin is a potent, long acting vasoconstrictor produced by vascular endothelial cells. The known biological effect of ET-1 are believed to be mediated principally through the Eta receptor. These include potent and uniquely sustained vasoconstriction of vascular smooth muscle, positive inotropy of myocardium, and the stimulation of cell proliferation or the hypertrophy in vascular smooth muscle cells, cardiac myocytes, and fibroblasts.

In vitro studies in cultured cells have established that ABT-627 selectively binds to the Eta receptor, and that ABT-627 is a potent inhibitor of ET-1 binding to the Eta receptor.

Studies in cultured human prostate cancer cells and other cultured cells have shown that ABT-627 acts as a functional antagonist of ET-1, and these effects have been confirmed in vivo by assessing the effect of ABT-627 on the ET-1 induced pressor response in rats. Further animal studies have suggested that oral ABT-627 may be effective in the treatment of congestive heart failure, pulmonary hypertension, hypertension, arterial restenosis, and myocardial infarction.

In addition to literature and animal models supporting the role of endothelin antagonists in cardiovascular indications, data exists supporting the role of the ET-1 cytokine as a pathogenic mediator in cancer.

The current role of endothelin in the manifestations of metastatic prostate cancer (PCA) and other tumors have yet to be fully defined. However, Abbott scientists and thought leaders have made multiple observations about endothelin biology which suggest that endothelin may play a role in the biology and pathophysiology of metastatic prostate disease and other metastatic disease such as ovarian, cervical and renal tumors.

ABT-627 has successfully completed Phase II trials for PCA, and the results demonstrate efficacy in hormone refractory PCA. The end of Phase II meeting with the FDA was held on October 4th. The data from Phase II was very favorably received and "best package" comments were made. Fast track designation and rolling NDA were granted. The FDA was conceptually in agreement with preliminary design of Phase III clinicals and clinical end points to measure. While not a dictate, a second Phase III trial will likely be conducted to insure the best opportunity for a successful outcome. The Phase III program is scheduled to commence before year-end. It is expected that filing on ABT 627 will occur in US and ex-US 1Q 2004. The compound is also in Phase I trials for other cancer types. Phase II studies in other cancer types will commence in 2Q01. Other indications outside of oncology are also being considered, to optimize the commercial potential of this asset.

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The US Market

Prostate cancer is the most common cancer to strike nonsmoking men. The NCI estimates that there are over 1.7 million men living with prostate cancer in the U.S., and another 179,300 will be diagnosed in 1999. Nearly 80% of these cases are men over 60 years of age. It is estimated that the prevalence of prostate cancer is 380,000 in Western Europe and 45,000 in Japan. While the vast majority of these patients will be identified with potentially curable disease (25% in Stage I and 50% in Stage II) in the U.S., half of these patients will go undiagnosed until late stage disease in W. Europe and Japan. The skewed distribution of diagnosed cases ex-U.S. is largely due to less aggressive prostate cancer screening programs compared to the U.S.

Prostate cancer has seen few additions or innovations in treatment regimens in the past two decades. Treatments remain, in general, radical prostatectomy (RP) for localized disease, radiotherapy for locally advanced disease and hormone therapy for advanced disease. Patients receiving hormone therapy become refractory to this treatment after two to three years, although many will continue on hormone therapy. These hormone refractory prostate cancer (HRPCa) patients usually have a life expectancy of approximately 12 months, and no existing standard of care exists for treating these patients. No therapy has shown a significant impact on survival in these patients, although some chemotherapeutic regimens may offer promise.

There is a general trend toward using hormone therapy in earlier stage patients. In some centers, patients are receiving hormone therapy prior to surgery or radiation, in an attempt to improve outcomes in these definitive treatments. Some thought leaders suggest that this earlier utilization has contributed to the overall mortality improvements in PCA. Studies are ongoing looking at different uses for hormone therapy, including intermittent therapy, in an attempt to improve outcomes and mitigate the morbidity associated with hormonal therapy.

Hormone therapy remains the mainstay of prostate cancer treatment in earlier stages. Chemotherapy, however, has gained additional attention in hormone refractory disease as new combinations and regimens offer the potential for greater therapeutic benefit with fewer side-effects. This trend will take several years before clinical trials are completed and community based oncologists adopt these regimens, so the current cytotoxic market in PCA is small.

The total dollar growth of this market has slowed as the two market leaders, Lupron (leuprolide/TAP) and Zoladex (goserelin/Zeneca), have experienced increased price pressures from managed care and Medicare. About half the states are currently reimbursing these therapies at a least cost option (only paying for the cheapest alternative), putting downward price pressures on Lupron (\$6,500/yr) to match Zoladex's (\$4,500/yr) lower price point. Thus, US Lupron dollar sales declined between 1997 and 1998, despite an increase in patient volume.

Growth has also stagnated due to a lack of innovation in this hormone dominated category. There have been few therapeutic advances in the treatment of PCA in the last 5 years.

The only chemotherapy approved for use in HRPCa patients with pain is Novantrone (mitoxantrone/Immunex), but the marginal benefits this compound delivers is deeply undercut by its severe toxicities and a lifetime cap on dose. Novantrone and steroids significantly reduced the metastatic pain in 40% of patients, but it does not appear to provide a survival advantage. Novantrone is dosed by i.v. infusion every 21 days, at a cost of \$560 per treatment, or an annual cost of around \$8,000. Use of this agent is associated with significant side-effects, including myelosuppression, cardiac toxicity (which limits dosing) and nausea. It is this negative side-effect profile that inhibits the use of this agent in more patients. Only about 4% of U.S. HRPCa patients received Novantrone therapy in 1998. Novantrone has not been approved ex-US.

Only about 17% of HRPCa patients received any chemotherapy in 1998. The most common drugs included estramustine, paclitaxel and etoposide. These drugs continue to be some of the most studied compounds in HRPCa ongoing research and represent the greatest short-term promise in the cytotoxic treatment of this advanced disease state.

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US Sales of Products to Treat Prostate Cancer

Product	1997 Dollar Sales (MM)	1998 Dollar Sales (MM)	% chng '97-'98
Lupron (leuprolide/TAP)	\$650	\$667	2.6%
Zoladex (goserelin/Zeneca)	233	296	27.3
Casodex (bicalutamide/Zeneca)	58	68	17.24
Eufixen (flutamide/Schering)	74	67	-9.5
Novantrone (mitoxantrone/Immunex)	33	35	6.1
Nilandrone (nilutamide/Hoechst)	12	24	100
Emcyt (estramustine/Pharmacia/Upjohn)	8	14	75
Taxol (paclitaxel/BMS)	4	8	100
VePesid (etoposide/BMS)	5	4	-20
Others	27	31	14.8
Total	1,104	1,214	10%

Source: Tandem Research and Price Probe

US Market Projections

- Novantrone (mitoxantrone/Immunex) is currently the only product approved for the treatment of hormone refractory PCA with pain. It currently falls short on the market needs in terms of efficacy and side-effect profile.

Attribute	Novantrone Profile
Dosing	I.V. infusion cycles
Cost	Expensive, ~\$10,000/yr
Efficacy	Provides marginal improvements in quality of life
Reimbursed	Yes
Side-effects	Dose limiting toxicities
Promo Efforts	108 oncology reps
Targets	Oncologists

Several surveys indicate that there are over 100 compounds in preclinical and clinical development for prostate cancer and various solid tumors. The compounds listed in the appendix represent compounds that appear to offer the greatest promise and/or potential for competition for ABT-627. However, since the most likely use of ABT-627 will be in combination with best therapy, it is difficult to define the extent of competitive threat that any of these compounds represent. In general, other cytostatic agents probably offer the greatest threat as a replacement for ABT-627. However, even other cytostatic agents may be combined to maximize the activity of the various mechanisms.

To date, PPD is aware of only one other endothelin receptor antagonist in development for cancer, from Yamanouchi, which began Phase I studies in the Fall of 1999. ABT-627 is still poised to be the first endothelin receptor antagonist to reach the market for oncology.

Scientific Rationale for ABT-627

There are relatively low hurdles for entry for a product to treat hormone refractory prostate cancer, as no truly effective agents presently exists. Quality of life is paramount in this population, followed by improvements in disease progression and survival. Quality of life parameters could include an impact on pain/or delay in pain onset or other performance type measures of daily activities. As all hormone therapy ultimately fails, a product that delays disease progression is needed.

Unmet Need	Pipeline Impact
Improvements in QOL	<ul style="list-style-type: none"> ABT-627's profile goal is to provide improvements to a patient's QOL or blunt a decrease in QOL Cytotoxic agents rarely have significant positive impacts on QOL Other cytostatic agents may offer this benefit
Improvements in survival	<ul style="list-style-type: none"> It is unlikely that improvements in survival will be seen in our current trials Cytotoxic agents may offer a survival advantage, perhaps in combination with ABT-627
Improvements in time to disease progression	<ul style="list-style-type: none"> Cytostatic and cytotoxic agents offer the greatest promise for this benefit

Our objective is to provide physicians and patients with a novel option for the treatment of hormone refractory prostate cancer, distinguish ABT-627 from current cytotoxic therapies and encourage the treatment of advanced prostate cancer patients currently only receiving hormonal therapy.

ABT-627 will be positioned as a physician and patient-friendly choice for advanced prostate cancer patients who have failed hormone therapy. ABT-627's novel mechanism of action provides a delay in disease progression and a positive impact on QOL. The oral, QD dosing enhances compliance and minimizes disruptions to daily living.

The message will focus on 3 key attributes:

- Efficacy (defined as increased time to tumor progression) in a patient group with few options
- Improvements in quality of life
- Convenience

Physicians no longer have to choose between *treating* advanced prostate cancer patients and a patient's quality of life. ABT-627 has a positive impact on disease progression and symptoms associated with quality of life, without the baggage of significant side-effects or the inconvenience of parenteral administration associated with current therapy choices.

This message expresses the key features of the agent in terms of patient benefits, as opposed to emphasizing the scientific/clinical aspects. Since prostate cancer is a terminal disease with a relatively long time for disease progression, the quality of a patient's life becomes even more critical. Especially in cancer treatment, where the therapy can often feel worse than the disease, the benefits that ABT-627 will bring, coupled with its benign side-effect profile, will have a significant impact on prostate cancer patients' lives.

Clinical Studies

Phase II trials have been completed and the data are being analyzed. Preliminary results for the primary endpoint of time-to-disease progression and the secondary endpoint of time-to-PSA progression show that ABT-627 favorably delays both phenomena with a benign adverse event profile. The results are summarized below.

Disease Progression: The delay in median time-to-disease progression for evaluable subjects was improved by 52% and 43% for the 10mg and 2.5mg doses respectively over the placebo time-to-disease progression of 4.3 months.

Time-to-PSA Increase: A 150% and 150% improvement in median time-to-PSA progression for evaluable subjects was observed for the 10mg and 2.5mg doses respectively over the time-to-PSA progression placebo of 2 months.

Significant dose related decreases were observed in markers of metastatic bone disease.

Key Prostate Cancer Competitors

Product	Company	Phase	Projected NDA Filing	Description	Anticipated Impact on ABT-627
AG 3340	Agouron	III	2000	MMPI	In combination with mitoxantrone/prednisone. Unknown impact.
Marimastat	British Biotech	II	2001	MMPI	Side-effect profile significantly worse than ABT-627. Probably minimal impact.
SU 101	Sugen	III	2002	PDGF TK antagonist	Phase III in combination with mitoxantrone set to start in 1999. Uncertain impact.
AR 623	Aronex	II	2002	All-transretinoic acid	IV liposomal form of ATRA. HRPc trial began November 1998. Probably additive.
MGI 114	MGI Pharma	II	2002	Alkylating agent	Lead compound in acylfulvenes. Fairly toxic. Probably additive.
Liposomal Encapsulated doxorubicin	NeoPharm and P&U/Alza and others	II	2002	Anthracycline	Various forms being developed by various companies. Probably additive.
Satraplatin	BMS	III	2000	Platinum complex	Oral platinum analog w/toxicities comparable to carboplatin. Probably additive.
Taxol	BMS	II	2001	taxane	In various combinations with other chemo agents. Probably additive.
Taxotere	RPR	II	2001	taxane	In various combinations with other chemo agents. Probably additive.

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ABT-594

Descriptive Memorandum

February 2001

Abbott Laboratories

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ABT-594 Opportunity Overview

ABT-594 is a non-opioid, non-NSAID analgesic that is a potent and selective neuronal nicotinic receptor (NNR) agonist being studied for the treatment of pain. ABT-594 is 30 to 100-fold more potent and equally efficacious to morphine in several well-characterized animal models of pain. The preclinical side effect and dependency liability profile of ABT-594 is superior to that of morphine.

ABT-594 is orally administered, and BID dosing is expected. Its initial targeted indication is symptomatic treatment of diabetic neuropathic pain. It is covered by a composition of matter patent through June of 2016, and also has a use patent pending in analgesia that would provide protection through September of 2017.

The IND filing of ABT-594 was in December 1998. A Phase IIb (dose ranging) trial began April 2000 in diabetic neuropathic pain. A Go/No Go decision for clinical efficacy is expected June 2001. The NDA filing is expected in 3Q2003. Development of additional formulations is under consideration (parenteral, transdermal, extended-release).

U.S. sales in 1999 for the key neuropathic pain treatments, Neurontin, carbamazepine, and tricyclic antidepressants (TCAs), are estimated to be \$350 million. Neurontin sales account for the bulk of this, with an estimated 40% of this antiepileptic drug's sales being for neuropathic pain. Neurontin's 2000 sales are expected to reach \$1 billion with perhaps 50% of its use in neuropathic pain. This dollar market value likely underestimates this market's potential due to a number of factors. Only the anticonvulsant, Tegretol (carbamazepine), currently off patent, and Lidoderm, a lidocaine patch, have specific indications for a type of neuropathic pain (trigeminal neuralgia and post-herpetic neuralgia, respectively) in the U.S. Currently, there is an unmet market need for novel neuropathic pain treatments such as ABT-594. Therefore, this compound is likely to be well received in this arena. Outside the U.S., Neurontin recently received an indication in the U.K. for the treatment of neuropathic pain. Despite these opportunities, there has been little to no funding from the pharmaceutical industry to improve diagnosis and treatment of neuropathic pain and drive market growth.

Ex-U.S. sales of carbamazepine and Neurontin for treatment of neuropathic pain are estimated to be approximately \$140MM in 1999. Carbamazepine is still the treatment of choice ex-U.S., with estimated sales of approximately \$90MM in neuropathic pain. Neurontin has achieved only \$53MM in sales for this pain segment, with a price approximately 3-4 times that of carbamazepine, suggesting a patient share of only 10-20%.

Nociceptive pain is categorized by duration (acute or chronic) and by severity (mild, moderate, and severe). The mild and, to a lesser extent, moderate segments have multiple product entries and are generally well satisfied by OTC products such as aspirin, acetaminophen and ibuprofen. The prescription market for nociceptive pain is made up of four key classes of analgesics: NSAIDs, COX-2s, Opioids (and combination products), and Other Non-Opioids. In 1999, sales for these four classes of analgesics exceeded \$12BB (\$6.7BB U.S., \$5.6BB Ex-U.S.)

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Market Size / Prevalence

Pain is the most common symptom of disease and the most frequent complaint with which patients present to physicians. Chronic pain, including both neuropathic and nociceptive pain, is considered to be the single most common cause of suffering and disability in the industrialized world with an estimated 25-30% of the population experiencing some form of chronic pain.

Neuropathic pain is a frequent sequela of diabetes, cancer, AIDS and other viral infections, as well as entrapment neuropathies such as carpal tunnel syndrome. Diabetes and its associated complications are increasing at an alarming rate in the United States. Despite advances in treatment, the development of diabetic complications such as neuropathy remains significant. The diagnosed prevalence of diabetic neuropathy is estimated to be about 2 to 3 million patients, with at least 10 to 20% of those patients experiencing painful symptoms (~200,000 to 600,000.) AIDS-related neuropathic pain is estimated to affect approximately 40% of HIV-infected individuals (~14 million.) Post-herpetic neuralgia (PHN) is another virally induced neuropathic pain syndrome. Annually, acute herpes zoster infection (shingles) occurs in almost a quarter of a million people over the age of 60 in the U.S. alone. Pain lasting more than one year has been reported in 22% of patients over the age of 55 and in 48% of those over 70 years of age. In cancer, nerves can be damaged by mechanical distortion from a tumor mass, infiltration by tumor, chemotherapy, or radiation therapy and, therefore, neuropathic pain is common. An estimate of the prevalence rate for cancer-related neuropathic pain in the U.S. is 200,000 people.

Chronic nociceptive pain categories include osteoarthritis (OA), chronic back and neck pain, rheumatoid arthritis (RA), and cancer pain. These diagnoses are expected to become more prevalent as the population ages. Current overall prevalence for these disorders is staggering (over 200 million worldwide) and, although the diagnosed and treated populations are lower, improved treatment options and awareness have the potential to drive significant growth. OA is one of the most common nociceptive pain conditions treated by primary care physicians and three-fourths of OA sufferers surveyed indicate that the disease interferes with their daily activities. Chronic back and neck pain are also highly prevalent and represent an estimated 40% of a primary care physician's (PCP's) chronic pain patient population.

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Competition, Current Marketed Products:

The following tables show the factored U.S. and ex-U.S. prescription and sales volume for key neuropathic pain therapies in 1999.

1999 Key Neuropathic Pain Products, Estimated TRxs				
Product/Class	1999 U.S. TRx (MM)	U.S. TRx CAGR '97-'99	1999 ex-U.S. TRx (MM)	ex-U.S. TRx CAGR '97-'99
Neurontin	3.3	26.3%	N/A	N/A
carbamazepine	1.0	12.6%	N/A	N/A
TCAs	8.2	1.1%	N/A	N/A
TOTAL	12.5	5.6%	N/A	N/A
Source: IMS, factored for neuropathic uses.				
N/A = not available				

1999 Key Neuropathic Pain Products, Estimated \$ Sales				
Product/Class	1999 U.S. Sales (\$MM)	U.S. Sales CAGR '97-'99	1999 ex-U.S. Sales (\$MM)	ex-U.S. Sales CAGR '97-'99
Neurontin	\$308	28.7%	\$53	57.6%
carbamazepine	\$17	13.1%	\$87	2.5%
TCAs	\$26	-3.3%	N/A	N/A
TOTAL	\$351	21.7%	\$140	10.1%
Source: IMS, factored for neuropathic uses; Ex-U.S. data includes retail pharmacy data from all audited markets				
N/A = not available				

Competition, Products in Development

Almost 100 compounds are currently in development for prescription pain management, though some of these compounds are also being developed for non-analgesic indications. Most of the analgesic compounds in the pipeline represent incremental improvements over the opioids or NSAIDs, or consist of new formulations or delivery mechanisms for the standard analgesics. Fewer than 30% of the compounds in development have novel mechanisms of action. Drugs with novel mechanisms are expected to provide the bulk of promoted competition for ABT-594.

In addition to the novel analgesics in the table below, a number of new formulation and combination products, most often containing an opioid, are in development. Second generation COX-2s are also in development but are not likely to represent major breakthroughs on the scale of the first generation products.

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Analgesia Development Pipeline – Key Novel Agents				
Product	Company	Mechanism	Phase	Comments
pregabalin	Pfizer	Unknown; possibly through (2 nd subunit binding	III	Neuropathic pain; chronic pain, follow-up to Neurontin
saregutant	Sanofi	NK-2 receptor antagonist	II	General pain; MOA losing favor; active program
ZD4952, ZD 6416	Zeneca	Prostaglandin receptor antagonist	II	Moderate to severe pain, neurogenic pain
GV196771	Glaxo	Glycine antagonist	II	Chronic pain; showing promise
Tepoxalin	Johnson & Johnson	COX/5-LO inhibitor	II	OA, described as 'steroid replacing anti-inflammatory drug'
darbufelone	Parke-Davis	COX/5-LO inhibitor	II	General pain
117mSn DTPA	Brookhaven National Lab/Diatide	Unknown	II	Cancer pain Bone cancer (preclinical)
cizacirtine	Esteve	Substance P agonist	II	Analgesia, antipyretic
ADD 234037/ harkoseride	Houston University	Glycine NMDA associated antagonist	II	Neurogenic pain
LY303870/ lanepitant	Eli Lilly	Neurokinin 1 antagonist	II	Pain (migraine – discontinued)
colykade devacade	Merck	Cholecystokinin B antagonists	II	Pain (UK)
RPR 100893 dapitant	Aventis	Neurokinin 1 antagonist	II	Pain (France)
prosaptide TX14A	Myelos Neurosciences	Unknown	I/II	Diabetic neuropathies, Pain
CNS 5161	Cambridge NeuroScience	Glutamate antagonist, NMDA receptor antagonist	I	Neurogenic pain
HCT-3012	NicOx	Nitric oxide NSAID	I	Pain and inflammation
Sources: ADIS, IMS, Decision Resources, company reports				

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Analgesia Development Pipeline – Nicotinic Mechanisms			
Product	Company	Phase	Comments
GTS-21	Taisho	II	Target is Alzheimer's disease; may have preclinical pain program; looking for partner
CMI 980	Cytomed	Preclinical	Target is pain; eptibatidine analog
SIB-T1887	Sibia	Preclinical	Target is pain
FID 072021	Fidia	Preclinical	Target is pain; not actively funding
Sources: ADIS, IMS, company reports			

Unmet Needs

In general, a significant unmet need exists for safer, non-abusable, non-addicting, non-tolerance-producing, and non-scheduled efficacious oral and parenteral analgesic products for the treatment of moderate to severe neuropathic and chronic nociceptive pain.

Unmet Market Needs and the Impact of the Pipeline	
Unmet Need	Pipeline Impact
Efficacy in moderate to severe pain without tolerance, dependence or abuse potential	Novel nicotinic agents like ABT-594 may provide efficacy in more severe pain states without opioid-like liabilities.
Efficacy in neuropathic pain	Pregabalin may provide incremental improvement in neuropathic pain efficacy over gabapentin, but may also have increased frequency of adverse events. Novel nicotinic agents like ABT-594 appear to have efficacy in neuropathic pain, based on animal models.
Reduction in the GI bleeding risk of NSAIDs	COX-2 inhibitors appear to reduce the incidence and severity of GI ulcers and bleeding; second generation COX-2s may increase therapeutic window further; ABT-594 may need to demonstrate low GI complication rate.
Overcome ceiling effect of NSAIDs	Predclinical studies did not indicate a ceiling effect for novel nicotinic agents like ABT-594.
Extended dosage intervals or novel delivery mechanisms for improved compliance and convenience	Once weekly dosing formulations being explored for COX-2s, etc. Transdermal patch technology improvements likely; may need to provide line-extension / alternate formulations for ABT-594.
Therapies aimed at disease modification, prevention	Agents that decrease rate of diabetic complications (e.g., aldose reductase inhibitors) or directly treat neuropathy (bimoclonol) may decrease incidence of neuropathic pain; thereby decreasing available market for ABT-594.

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Product / Development Background

Scientific Rationale for ABT-594

Recent findings in the understanding of pain mechanisms have led to new conceptual approaches to clinical pain and a new understanding of potential novel molecular targets for analgesic drug development. Molecular targets have included modulators of glutamate neurotransmission (NMDA antagonists), ion channel modulators (neuron specific calcium channels, TTX-resistant sodium channels), neurokinin antagonists (NK-1), and novel anti-epileptics targeting the calcium receptor. None of these approaches has yet produced compounds exhibiting broad-spectrum analgesic efficacy with decreased side effect liability.

ABT-594 is a non-opioid, non-NSAID analgesic that is 30- to 100-fold more potent and equally efficacious to morphine in treating moderate to severe pain in several well-characterized animal models of pain. The preclinical side effect and dependence liability profile of ABT-594 is superior to that of morphine. Mechanistically, ABT-594 is a potent and selective neuronal nicotinic receptor (NNR) agonist with high oral bioavailability in rat, dog, and monkey.

In pre-clinical studies, ABT-594 rapidly distributes to the brain following systemic administration and, like morphine, can work at multiple levels in the central and peripheral nervous system to modulate pain perception. ABT-594 produces antinociceptive effects by interacting at both central and peripheral nAChRs. Injections of ABT-594 into brain at doses 1000-fold lower than given peripherally produce marked antinociceptive activity, indicating that ABT-594 can also activate descending pathways from the CNS to modulate pain processing. It also inhibits the release of the primary nociceptive transmitters, substance P and calcitonin gene related peptide (CGRP) *in vitro*, at the level of the dorsal horn of the spinal cord suggesting that ABT-594 can attenuate mechanisms leading to neurogenic inflammation, central sensitization and consolidation of pain-mediated neuronal changes.

ABT-594 is expected to be a highly differentiated product. It is expected to be the first neuronal nicotinic receptor agonist to receive an indication for pain. It has a novel mechanism of action and a potentially broad coverage of chronic pain conditions. In addition, it has an opioid-like efficacy without tolerance, dependence or abuse potential, while having equivalent/superior efficacy to other drugs used to treat neuropathic pain.

Clinical Studies

Human clinical trials began in 1997. Phase I trials with an oral solution formulation indicated that 150ug/day would be the maximum tolerated dose. Results from subsequent phase I and phase II trials with soft elastic capsule (SEC) and hard gelatin capsule (HGC) suggest that higher doses would be tolerated. Phase IIa studies with ABT-594 SEC formulation suggest a trend towards analgesic effect at 75ug BID, the maximum dose studied in this protocol. ABT-594 was generally well tolerated in these studies. The most common adverse events for subjects receiving ABT-594 75ug BID were nausea (15%), headache (13%), dizziness (7%), insomnia (6%), and vomiting (5%).

A phase IIb study for neuropathic pain at higher, titrated doses of ABT-594 began in April 2000 and ends in June 2001. A total of 320 patients is anticipated to be included in the study.

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Considerations**Target Profile:**

The current status of ABT-594's profile vs. target profile is summarized in the table below:

Target Profile Attribute	Probability
Not scheduled (DEA)	High
Very few abnormal Liver Function Tests	High
Few Drug interactions	High
BID / TID dosing	High
No reduced efficacy or increased AEs in nicotine users	High
Onset of action 1.5 – 2.0 hours	High
Neuropathic efficacy	Medium
No tolerance, dependence or withdrawal	Medium
Other safety OK	Medium
No cravings in ex-nicotine users	Medium
Low nausea / vomiting	Low

Label Strategy:

BASE: Indicated for the treatment of diabetic neuropathic pain.

- UPSIDE:
- 1) Treatment of pain associated with OA
 - 2) Treatment of post-herpetic neuralgia
 - 3) Treatment of neuropathic pain
 - 4) Treatment of chronic pain
 - 5) Treatment of cancer pain

Cost of Goods Sold:

The projected average daily dose is expected to be a maximum of approximately 600 mcg base equivalent / day. Based upon this dosage projection and the estimated cost of bulk drug substance of \$40M per Kg base equivalent, the estimated cost for drug substance at launch will be approximately \$0.024 per day.

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Pricing:

US: Pricing new, and particularly novel, products at a reasonable premium will likely continue to be the norm in the years leading up to the launch of ABT-594. Current forecast assumptions put the price of ABT-594 at a level comparable to Celebrex and Neurontin, grown at a modest 2% per year to launch year AWP of approximately \$95 for a 30 day prescription.

Ex-US: New pain medications must demonstrate a true advantage in efficacy and/or side effects to receive regulatory approval, especially by the European Medicines Evaluation Agency (EMA); assuming the target efficacy and tolerability profile of ABT-594 is achieved, ABT-594 would meet this requirement. Because ABT-594 may have application in both neuropathic and chronic nociceptive pain, the ex-U.S. pricing assumption for ABT-594 is comparable to COX-2 pricing. The current average price for COX-2's is approximately \$1.10 per day; however, this reflects a large percentage of sales in "free-pricing" countries, where COX-2s launched first, which tend to have higher than average prices. Therefore, the average ex-U.S. price for ABT-594 is assumed to be \$0.90/day.

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ABT - 751

Descriptive Memorandum

February 2001

Abbott Laboratories

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ABT-751

Opportunity Overview

Cytotoxic agents and hormones constitute the dominant classes of drugs available to treat cancer and are responsible for 98% of the total market. Since 1993, Taxol, a taxane developed and marketed by BMS, has been widely used. Another taxane, Taxotere, developed and marketed by Aventis, was launched in 1996. Combined worldwide sales of these two products were of nearly \$2 Billion US in 1999. Clinically, the development of drug resistance is the primary factor that limits the efficacy achievable with these drugs.

Abbott's anti-mitotic agent (ABT-751) is a novel, oral cytotoxic agent that acts by a mechanism similar to that of the taxanes but retains activity against taxane resistant cells. ABT-751 binds to the colchicine site on tubulin and inhibits the *in vitro* polymerization of microtubules. The interference with normal microtubule dynamics leads to a block in the cell cycle at the G2/M phase that ultimately results in the induction of cellular apoptosis. ABT-751 is a potent antimitotic agent that inhibits the proliferation of a broad spectrum of human tumor derived cell lines including those that are paclitaxel and doxorubicin resistant due to the multidrug-resistant (MDR) phenotype or other genetic changes.

ABT-751 demonstrated impressive oral antitumor activity when evaluated in both synegeic and human xenograft tumor models. The antitumor response was independent of the MDR status of the model, consistent with the activity observed in cell cultures. In sharp contrast with other cytotoxic drugs, the maximum tolerated dosage of ABT-751, on a q.d. 1-5 schedule, could be administered for an extended period (q.d. 1-21 or q.d. 1-28) resulting in a dramatic enhancement of the antitumor activity. These results suggest that the colchicine site ligands, such as ABT-751, will exhibit a broad spectrum of activity that will be distinct from that of other classes of antimitotic drugs. Oral availability of the compound is high. Taxol and Taxotere, in contrast, have no oral bioavailability.

The most significant finding in toxicology studies was a change in systemic and pulmonary vascular resistance following intravenous infusion of ABT-751 to anesthetized dogs. These effects led to an inverse response in cardiac output. Similar changes were observed following infusion of a structurally unrelated colchicine-site ligand, and therefore most likely represent a class effect. Additional toxicology studies focusing on vascular pathology will be performed to further elucidate this finding.

ABT-751 was administered to patients with advanced cancer in Japan in a Phase I study. Toxicities seen after single doses and 5 days of q.d. dosing were nausea, vomiting, diarrhea, epigastric pain, ileus and peripheral neuropathy. Grade 2 toxicity was peripheral neuropathy and associated paresthesias. Pharmacokinetic analyses showed plasma concentrations equivalent to those that affected systemic resistance and cardiac output in the anesthetized dog study. However, no adverse cardiovascular effects were observed in the Japanese Phase I trial. Evidence of ABT-751 efficacy was exhibited in one patient with uterine sarcoma, one patient with NSCLC after single doses, one patient with gastric cancer and one patient with uterine cervical carcinoma demonstrated decreased tumor markers after repeated dosing.

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The planned initial Phase I study in the U.S. will determine the maximum tolerated dose and dose-limiting toxicities of ABT-751 given orally once a day or twice daily for multiple cycles in patients with advanced malignancies. In addition, pharmacokinetics in a western population, and optimal dose and schedule will be determined. Phase II studies will be initiated in patients with different cancer types:

- Refractory breast (taxane failures)
- Hormone refractory prostate
- Bladder
- Lung
- Cervical
- Hepatocellular
- Other possibilities: colorectal, sarcoma, renal cell, pancreatic, HNSCC

Cytotoxic agents represent the largest, and fastest growing, class of oncology agents by sales volume. The following chart summarizes the value of the current oncology market

Global Sales by Market Segment (\$ MM)

	1996 Sales	1997 Sales	1998 Sales	1999 Sales (est)	CAGR '96-'98
Hormone	4,414	4,784	4,884	5,000	5.2%
Cytotoxic	4,278	5,212	6,268	7,300	21.0%
Adjunctive	3,367	3,651	4,166	4,900	11.2%
Total	12,059	13,647	15,318	17,200	12.7%

Source: Datamonitor

Sales by Region (\$ MM)

	1996 Sales	1997 Sales	1998 Sales	1999 Sales (est)	CAGR '96-'98
US	5,564	6,276	7,422	8,500	15.5%
Ex- US	6,495	7,370	7,896	8,700	10.3%

Source: Datamonitor

This growth of the cytotoxic segment has been driven primarily by the introduction of new, more effective and expensive therapies such as Taxol (paclitaxel/BMS), Gemzar (gemcitabine/Lilly), Taxotere (docetaxel/RPR) and Hycamtin (topotecan/SB). Uptake of these newer agents, however, can be dependent on the cost sensitivity of the local market.

The clinical targets identified for this compound include late stage breast cancer, late stage NSCL cancer (on-label), with late stage ovarian and pancreatic cancer as additional cancer types where efficacy has been demonstrated, but not filed. This product may also be potentially efficacious in cancers such as gastric, colorectal, prostate, bladder, esophageal, hepatocellular (ex US), lymphoma, and leukemia. Targets will be refined as we know more about this compound's in-vivo activity.

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The following tables summarize the key competitive products by indication (US data only):

Late Stage Breast	
Product	Share
Cyclophosphamide/Cytoxan/BMS	18.7
Doxorubicin/Adriamycin/P&U	17.11
Docetaxel/Taxotere/RPR	16.25
Paclitaxel/Taxol/BMS	16.11
Trastuzumab/Herceptin/Genetech	11.26

Late Stage NSCL	
Product	Share
Carboplatin/Paraplatin/BMS	50.32
Paclitaxel/Taxol/BMS	44.14
Vinorelbine/Navelbine/Glaxo	22.78
Gemcitabine/Gemzar/Lilly	22.14
Cisplatin/Platinol/BMS	11.28

Late Stage Ovarian	
Product	Share
Paclitaxel/Taxol/BMS	47.11
Carboplatin/Paraplatin/BMS	45.42
Topotecan/Hycamtin/SKB	22.54
Dox SL/Doxil/Alza	9.14
Cisplatin/Platinol/BMS	7.58

Late Stage Pancreas	
Product	Share
Gemcitabine/Gemzar/Lilly	78.5
5-FU/Efudex/ICN Pharma	21.0
Leucovorin/	10.7
Cisplatin/Platinol/BMS	4.72

Compounds in Development

ABT-751 induces a mitotic block by binding to the colchicine site on tubulin and thereby affecting tubulin polymerization. There are no currently available drugs which function by the mechanism described above. However, vinca alkaloids and taxanes fall into the broad category of anti-mitotics although they produce the anti-mitotic effect through different mechanisms. The following table summarizes anti-mitotic compounds in development.

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Company	Compound	Indication	Status of compound	Status of agent
Colchicine-site ligands				
Oxigene	combretastatin-A4 phosphate	Tumor vasculature	Phase I	active
Tularik	T138607 (phosphate prodrug)	Cancer (unspecified)	Phase I	active
Tularik	T900607	Cancer (unspecified)	Preclinical	active
ICI/CRC	Amphethinile	Cancer (unspecified)	Phase I (abandoned 1988)	inactive
Wellcome Research	1069C	Cancer (unspecified)	Phase I (abandoned 1996)	inactive
NIH	Trimethylcolchicinic acid	Various tumors	Phase I (1990, abandoned)	inactive
Parke-Davis	CI-980	ovarian, colorectal	Phase II (abandoned 2000)	inactive
Vinca alkaloid-site ligands				
BASF	LU103793 (dolastatin 15 analog)	Cancer (unspecified)	Phase II (abandoned)	active
Servier	Vinxaltine	Cancer (unspecified)	Phase I	unknown
NCI	dolastatin 10	Adv. Cancers	Phase I	unknown
Teikoku Hormone	TZT-1027 (dolastatin 10 analog)	Cancer (unspecified)	Phase I (Jpn)	unknown
Lilly	LY 355703 (cryptophycin 52)	Cancer (unspecified)	Preclinical	unknown
Takeda	Maltansine	Cancer (unspecified)	Preclinical	unknown
Microtubule stabilizing agents (non-taxanes)				
Soc. Biotech. Res/ Bristol-Myers Squibb	Epothilone	Cancer (unspecified)	Preclinical	active
Bristol-Myers Squibb	eleutherobin	Cancer (unspecified)	Preclinical	active
Pharmacia & Upjohn	sarcodictyins	Cancer (unspecified)	Preclinical	active
Takeda	GS-164	Cancer (unspecified)	Preclinical	active

The novelty of this mechanism offers the promise of differentiation that will diminish the threat from potential competitors. However, this novelty is balanced by the similarity to current mechanisms, such as taxanes and vinca alkaloids, which suggests the promise of clinical efficacy. With the opportunity to be first or second to market with an agent that binds to the colchicine site, the competitive situation seems modest.

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ABT – 492

Descriptive Memorandum

February 2001

Abbott Laboratories

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JH 008179**

Hancock_AB 492

ABT 492**Overview**

The commercial success of fluoroquinolones such as ciprofloxacin and levofloxacin, along with the desire to further improve the properties of these compounds (microbiological spectrum and safety, for example) has led to fierce competition to identify analogs with superior therapeutic properties. In addition, the development of resistance to present antibiotics will drive a continued need for new agents. Goals for a quinolone antibiotic include broad-spectrum indications equal to trovafloxacin, antibacterial activity comparable to trovafloxacin, tolerability comparable to levofloxacin, oral and intravenous formulations, once daily dosing, length of treatment equal to moxifloxacin, and an acceptable cost of goods. ABT-492, an in-licensed compound from the Wakunaga Pharmaceutical Co., is being developed for evaluation to meet these goals:

The *in vitro* antibacterial activity of ABT-492 was consistently more potent than trovafloxacin against most quinolone-susceptible pathogens, including species responsible for community and nosocomial respiratory tract infections, urinary tract infections, blood stream infections, skin and skin structure infections, and anaerobic infections. The compound has potent activity against multidrug-resistant *S. pneumoniae* (penicillin-, macrolide-, tetracycline-resistant) and retained activity against *S. pneumoniae* strains resistant to other quinolones including trovafloxacin. ABT-492 was also highly active against anaerobes and ciprofloxacin-susceptible *P. aeruginosa*. ABT-492 was as active as trovafloxacin against *C. trachomatis*, indicating good intracellular penetration. Thus, ABT-492 is likely to be a useful broad-spectrum antibacterial agent. The enhanced antibacterial activity of ABT-492 relative to ciprofloxacin, levofloxacin, and trovafloxacin is likely to be explained, in part, by its potent interactions with bacterial topoisomerases. ABT-492's equivalent activity against both the DNA gyrase and the topoisomerase IV of pathogens, give ABT-492 a potential for decreased development of resistance.

The *in vitro* potency data suggests that ABT-492 has the potential to be therapeutically effective at doses comparable to trovafloxacin and superior to levofloxacin. In addition, ABT-492 was consistently more potent than trovafloxacin against MRSA and vancomycin-resistant enterococci. In both these cases, however, therapeutic utility remains to be assessed in the clinical setting.

S. pneumoniae was chosen as the dose-defining pathogen since it is the key pathogen in severe respiratory tract infections and treatment of infections caused by this pathogen has traditionally been a weakness of most quinolones. For treatment of fluoroquinolone-susceptible *S. pneumoniae* respiratory tract infections, oral dosing may be similar to trovafloxacin based on data generated in lung infection models. Because of the excellent potency of ABT-492 against fluoroquinolone-resistant *S. pneumoniae* with an MIC₉₀ of 0.12 µg/ml, this group of emerging strains may be targeted as a key differentiation point from other quinolones. Also, data from the high infection model suggests significantly greater efficacy for ABT-492 than for trovafloxacin.

The Market

ABT-492 is broad-spectrum anti-infective agent with potential application across a broad range of indications, including respiratory infections, genito-urinary infections, and skin/soft tissue infections. It is assumed that a pediatric formulation would not be a part of the primary development plan due to the known adverse events caused by quinolones in pediatric populations. Nonetheless, reports of quinolone pediatric development has been reported (gatifloxacin), hence the pediatric market should be regarded as a potential upside for this quinolone should its safety profile merit its use in pediatrics.

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Current Treatment Options

Class	Mechanism of Action	Comments
Penicillins	Cell wall synthesis inhibitor	Mostly generic, class has seen significant decrease as a result of penicillin resistance
Cephalosporins	Cell wall synthesis inhibitor	Some generic, class has seen significant decrease in use as a result of prevalence of β -lactamase producing strains and modification of penicillin-binding proteins.
Tetracyclines	Protein synthesis inhibitor	Generic agents, relatively high levels of resistance but are still useful in some indications
Sulfonamides	Folic acid synthesis	Generic agents, relatively high levels of resistance but are still useful in some indications
Macrolides	Protein synthesis inhibitor	Widespread use in RTI, macrolide resistance has been increasing rapidly, but has not yet translated into declines in clinical efficacy; <i>H. flu</i> activity continues to be class weakness, along with GI adverse events, drug-drug interactions, & taste perversion
Quinolones	DNA synthesis inhibitor	Fastest growing antibiotic class, used in a broad spectrum of indications; class historically associated with poor Gram+ pathogen coverage and sub-optimal safety profiles; newer agents (Levaquin, Tequin, Avelox) have improved dramatically along both spectrum and safety dimensions.
Oxazolidinones	Protein synthesis inhibitor	Newest antibiotic class to reach market, due to limited Gram- profile will be used primarily in nosocomial setting

U.S. Market

1999 U.S. antibiotic prescription and sales data are presented in the table below.

		1995	1996	1997	1998	1999	CAGR ₁₉₉₅₋₉₉	
U.S.	TDx's (MM)	Tab/Cap	220	215	211	208	221	0.1%
		Oral Susp.	76	66	63	59	61	-5.3%
		I.V.	NA	NA	NA	NA	NA	NA
	Sales (\$MM)	Tab/Cap	\$4,057	\$4,220	\$4,467	\$4,848	\$5,715	8.9%
		Oral Susp.	\$1,075	\$979	\$977	\$1,001	\$1,120	1.0%
		I.V.	\$1,865	\$1,829	\$1,855	\$1,890	\$2,117	3.2%

Tab/cap and oral suspension prescriptions had been declining 1-2% per year in the period of 1995-1998, presumably from increased attention to appropriate prescribing in the face of increasing resistance; however, prescriptions recovered in 1999, though this may be explained at least in part by a relatively late 1998-99 flu season. Even in the face of this negative pressure on antibiotic use, however, sales in the U.S. have continued to increase, particularly in the tab/cap market. This is due to the trend of replacing relatively low-cost generic agents with higher priced premium antibiotics; during 1995-1999, generic tab/cap prescriptions declined by 30MM. So while negative pressure on the use of these antibiotics continues, it appears the market is willing to bear higher costs for agents that meet unmet need. The IV market has grown slightly in terms of sales, also being driven largely by the replacement of generic agents with more costly branded agents.

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Quinolones have seen dramatic growth, with oral and IV sales growing at 17% and 16% compound annual rates, respectively, from 1995-1999. This growth is a function of the newer quinolones successfully penetrating the RTI segment, which was initiated with the 1997 launches of Levaquin and Trovan (withdrawn) and continues with the recent introductions of Tequin and Avelox.

Ex-U.S. Market

Ex-U.S. sales of antibiotics totaled \$11.7 billion in 1999. The tab/cap represents the largest segment, with sales of \$9.4 billion on 770 MM TRX. TRX growth has been flat, with a 1996-99 CAGR of 0.5%; the use of antibiotics is predicted to slowly decline due to more judicious use of antibacterials in the face of increasing bacterial resistance.

Ex-US, the quinolone class accounted for 8% (62MM) of total tab/cap market prescriptions and 13% of sales (\$1.2 billion). Ciprofloxacin is the market leader ex-US, with approximately 47% of the quinolone market Rx's (29MM) and 44% (\$530MM) of sales. Levofloxacin launched in many European markets in 1998/1999 and holds approximately 14% Rx share of the European quinolone market, and 0.8% of the overall tab/cap market. Although grepafloxacin and trovafloxacin also launched in some European countries in 1999, both products were recently pulled from the market due to liver toxicity and other complications. Moxifloxacin launched in Germany in Q4 1999, but has not yet been approved in other markets. In Japan, levofloxacin launched in 1994 and still commands a 65% Rx share of the quinolone market and 10% of the Japanese tab/cap market overall. Japan accounts for approximately 80% of ex-US levofloxacin sales (\$370MM).

1999 Ex-US Tab/Cap Market						
Class	Sales (\$MM)	Sales Share	Sales CAGR '96-'99	TRXs (MM)	TRX Share	TRX CAGR '96-'99
Market	\$9,348	—	3.6%	770	—	0.8%
Quinolone Class	\$1219	13%	-12%	62	8%	NA
Cipro	\$530	5.7%	4.9%	29	3.8%	NA
Levaquin	\$466	5.0%	NA	18	2.3%	NA
Trovan	\$12	0.1%	NA	0.5	0.1%	NA

Competition

The anti-infective pipeline is very competitive, but most of the competition is focused on improving the activity and safety of the quinolones. Ketolide development is the only other area of activity which is in late stage of development. The quinolone compounds in present development may fall out because of safety or lack of activity against resistant pathogens.

Competitive Analysis - Emerging Competition					
Product	Company	Class	Phase/Estimated Time to Market	Country	Comment
Ketek (telithromycin)	Aventis	Ketolide	Filed 3/00 Est. launch 3/01	U.S.	Respiratory indications; filed NDA 3/00; 800 mg QD; first in ketolide class to reach market.

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Competitive Analysis – Emerging Competition					
Product	Company	Class	Phase/Estimated Time to Market	Country	Comment
Factive (gemifloxacin)	SKB	Quinolone	Filed 12/99 Est. launch 12/00	US	Superior to quinolones for MRSA; highly potent vs. RTI pathogens <i>H. flu.</i> , <i>M. cat.</i> and <i>S. pneumo</i> and UTI pathogens <i>E. coli</i> and <i>P. mirabilis</i> , CRSP; potency > spar, trov, gepa and \geq mox; activity vs. <i>P. aeruginosa</i> ; good atypical and mycoplasma coverage; intracellular penetration; low photo/CNS tox; 700 patient database
Sitafloxacin	Daiichi Seiyaku	Quinolone (IV only)	III II Est. launch 2002	Japan U.S., Europe	Very potent MRSA, pseudomonas and bacteroides activity; diarrhea, ALT, low WBC; will likely be target to severe rather than community infections
Eccnoxacin	Chiel Foods	Quinolone	II Est. launch 2002	UK	Active against UTI and RTI pathogens; superior to lome and oflo vs. <i>P. aeruginosa</i> . $T_{1/2}$ = 14-19 hr; will likely be target to severe rather than community infections
CS-940	Sankyo	Quinolone	II Est. launch 2002	Japan	Active against G+/-; excellent activity against <i>H. flu.</i> , <i>c. jejuni</i> , <i>M. pneumo</i> , and <i>C. trachomatis</i> ; greater potency than cipro; $t_{1/2}$ ~7 hr, BA~80%
T-3811	Toyama/BMS	Quinolone	I Est. launch 2005	Japan	Excellent potency and low toxicity
DC-756	Daiichi Pharma	Quinolone	Pre-clin Est. launch 2006	Japan	Low toxicity; in vitro potency \geq trov, STFX & HSR-903

Unmet Needs

Overall unmet need in the anti-infective market is low. Resistance represents the largest unmet need, which will continue to evolve over time. Satisfaction with other product attributes, such as convenience, spectrum of activity, and tolerability/safety is quite high. Any improvements in these areas will be incremental and will offer little in the way of differentiation.

ABT-492 is one of the most active agents against the resistant organisms. It has indications that will have a low propensity for the development of resistance. ABT-492 will be developed to maximize any opportunities to shorten therapy. ABT-492 was chosen from hundreds of quinolones because of its potential to be well tolerated and safe in humans. ABT-492 will have few interactions with other drugs.

Unmet Need	Pipeline Impact
Activity against resistant organisms	<i>Strep. pneumo</i> , MRSA, and VRE represent most problematic pathogens although new quinolones/ketolides do well with most resistant <i>Strep. pneumo</i> strains; quinolone-resistant <i>Strep. pneumo</i> may develop; pseudomonas resistance is also increasing; resistance will likely continue to be a source of unmet need due to its dynamic nature.
Low propensity for resistance development	Given that most compounds in development are from classes of drugs already in use, this need is largely unmet. Unclear how quickly resistance will build to new classes of drug; gatifloxacin claims 8-methoxy functional group results in lower propensity for resistance development
Convenience (duration/frequency)	Standard moves toward 5-7 days of therapy with QD dosing; may start to see 3-day therapies for some indications (AECB)
Increased tolerability	While some degree of unmet need exists, increasingly, agents (which have not been withdrawn) are reaching the marketplace with adverse event profiles that approach clinical insignificance; a very clean safety

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	profile should be regarded as a necessary component rather than a differentiating one
Few drug-drug interactions	Quinolones, macrolides, and ketolides all interact with other drugs to varying degrees; a potent drug with no interactions would be a benefit in this market

Considerations

Product Usage: Physicians are likely to use ABT-492 for the sicker patients with the most difficult infections to treat. In the outpatient arena it will be used to treat community-acquired pneumonia and acute bacterial exacerbations of chronic bronchitis in the older patients with an underlying illness. It will also be used in the hospital for the community-acquired pneumonia patient who requires hospitalization and for serious nosocomial infections.

While many regard quinolones as agents that should be reserved for 2nd line use, their activity against *H. influenzae* and resistant *Strep. pneumoniae* (which current macrolides do not offer) have resulted in a high level of acceptance for empiric 1st line use. The improved safety profiles of several recent quinolones have facilitated their use as 1st line agents. Provided that ABT-492 is proven to have a benign safety/adverse event profile, it will likely receive usage in both 1st-line (non-severe) and 2nd-line (severe) infections.

Side Effects: The quinolone class has potential prolongation of the QT interval and other cardiovascular effects. There is also increased regulatory scrutiny due to recent quinolone withdrawals from international markets. ABT-492 has been evaluated in the standard *in vivo* models used to evaluate QT interval potentials of other antibiotics and has shown no evidence of increasing QT. Also, compared to marketed quinolones, preclinical studies show no evidence or no increase incidence of CNS drug concentration (ie. less potential for dizziness); phototoxicity, and liver toxicity.

Off-label use: It is difficult to predict at this time what off-label uses will be seen for this compound. Initial development will be for the more common respiratory, urinary tract, skin, and hospital infections. Other indications will be evaluated after the primary approval of this compound. Many of the secondary indications will get usage before we have regulatory approval.

COGS: The initial cost of goods is in \$6000/kg range, but will come down rapidly after the initial starting materials are determined. At time of launch ABT-492 will have a cost of goods in the \$1500/kg range which is competitive compared to other quinolones and other new antibiotics.

Dosing: Based on animal models and the *in vitro* activity of ABT-492 the dose for most oral indications will be in the range of 100 to 200 mg give once daily.

Development/Regulatory. Anti-infective compounds are well understood by regulatory agencies globally and they have clearly defined clinical development path and regulatory guidelines for reference. Abbott Laboratories has been in this arena for many years and has experience with the FDA and European regulatory agencies and so the hurdles to development are well known. ABT-492 has begun but not yet completed its first Phase I study in healthy volunteers.

Other Approaches: Because of the well defined development guidelines there are not many options. The major development options are in dosing regimens. ABT-492 is a very potent drug which has demonstrated rapid killing of pathogens *in vitro* and *in vivo*, and the development plan will attempt to shorten treatment durations to increase the competitive advantages of this activity.

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Pricing: The community infection market is quite competitive from a pricing standpoint, with recent quinolones priced at approximately \$45 per 5-7 days of therapy. The pricing strategy will depend on strengths/weaknesses of the ABT-492 product label, the competitive landscape at launch, and the managed care environment, but current pricing assumption is parity for ABT-492 with respect to other quinolones.

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ABT – 510

Descriptive Memorandum

February 2001

Abbott Laboratories

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ABT 510

Overview

There is abundant evidence that primary tumor growth and metastatic progression require new blood vessel formation (angiogenesis). Tumors secrete inducer proteins including bFGF and VEGF that activate microvascular endothelial cells (EC) causing them to proliferate, migrate and organize into capillary structures. Activated endothelial cells also enhance malignant progression by producing signal molecules (cytokines) that inhibit programmed cell death (apoptosis) of tumor cells. Since anti-angiogenic therapy targets genetically stable endothelial cells, resistance typically seen following cytotoxic chemotherapy is not observed. Moreover, angiogenesis inhibitors should not have the intrinsic toxicity of anti-proliferative chemotherapy. Angiogenesis is also a feature of several other pathophysiologic states of large unmet medical need (macular degeneration, psoriasis, and arthritis, among others).

Angiogenesis sustains the growth and progression of tumors. Unlike chemotherapy or radiation, both of which can damage normal cells in addition to tumor cells, anti-angiogenic agents are hypothesized to prevent growth of new blood vessels and to disrupt critical tumor survival signals produced by EC. These agents may keep tumors in a dormant state for as long as the compound is administered and tumor regressions may occur. Proof of this principle has been demonstrated in pre-clinical models. Currently, at least thirteen compounds with anti-angiogenic activity in cancer are in various phases of clinical development, however few act directly and specifically on the angiogenesis process. Anti-angiogenesis drugs are not expected to replace or compete with current therapies. Instead, if these agents prove to be effective, it is believed that they will be used as supplemental therapy to prevent metastasis following surgery, cytotoxic chemotherapy or radiotherapy. As for cases where tumors have already metastasized, these agents could slow down disease progression and maintain "disease dormancy".

Thrombospondin-1 (TSP-1) was the first natural angiogenesis inhibitor to be discovered. TSP-1 is a large, multifunctional protein. TSP-1 rapidly inhibits EC migration and increases EC apoptosis through activation of caspase-3-like proteases. The normal tissue expression of TSP-1 limits inappropriate neovascularization, however it is transcriptionally activated by the tumor suppressor gene product p53. Therefore, TSP-1 is down-regulated and under-produced in p53 defective tumors. In rodent models, ectopic overexpression of TSP-1 inhibits the malignant phenotype as does direct administration of TSP-1 in the circulation. However, direct clinical use of TSP-1 is not feasible because of its scarcity, large size and multiple other biological functions.

The angiogenic activity of TSP-1 has been localized to the 50,000 MW N-terminal stalk region of this protein, and more specifically to the properdin (Type-1) repeats within this region. Although small synthetic peptides within this region have only weak antiangiogenic activity, it was discovered that a single D-amino acid replacement in a properdin region peptide led to an increase in activity of greater than 1000-fold. ABT-510 is a parenterally available nonapeptide. Although ABT-510 competes with TSP-1 for binding to the EC, the exact mechanism of anti-angiogenesis is unknown.

ABT 510 is supplied for clinical use as a sterile solution in acetate salt in 5% dextrose. ABT 510 is soluble and stable in water.

In vitro, ABT 510 inhibits chemotactic VEGF/bFGF-stimulated migration of human microvascular endothelial cells (EC) with an IC50 of approximately 0.250 nM. This effect is EC specific. ABT-510 (10mg/kg/day subcutaneously) blocks VEGF-induced corneal vascularization in mice. It potently and selectively competes with TSP-1, binding the CD 36 receptor.

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ABT 510 inhibits tumor progression in vivo. ABT 510 (20mg/kg/day subcutaneous administration) inhibited tumor progression (78% growth inhibition at day 38) in a model of human breast cancer (MDA-MB-435) growing in the breast pads of nude mice. Dose dependent inhibition of B16F10 melanoma lung metastases was observed in a second murine model. ABT 526, a molecule highly similar to ABT 510 (which was not advanced into human trials because of concatemer formation) was administered to 23 companion dogs (25mg SQ BID) with sporadic cancers (head and neck carcinoma, lymphoma, sarcoma, etc) refractory to conventional chemotherapy. Surprisingly, 2 complete responses, 5 partial responses ($\geq 50\%$ shrinkage) and 6 cases of disease stabilization were observed.

Assays for toxicity, histamine release, hemolysis, T-cell function neutrophil migration, platelet aggregation, receptor (CEREP) screening and CNS function were unremarkable. ABT-510 produced no physiologically significant changes in cardiovascular or hemodynamic function in anesthetized dogs. In addition, there were no physiologically significant changes in clinical blood chemistry profiles or cardiac electrophysiologic function in response to ABT-510. Doses that were many times higher than the predicted efficacious concentration produced a moderate reduction in mean arterial blood pressure in conscious monkeys. ABT-510 was not mutagenic in the Ames assay. It is concluded therefore that ABT-510 has an excellent pre-clinical safety profile.

ABT-510 is currently in Phase I clinical trials. Because of its exceptional safety profile, normal volunteers are being dosed with ABT-510 to establish human safety and pharmacokinetic parameters. Review of these data will lead to a Go/NoGo decision for Phase II trials in the Summer of 2001.

The market

Cytotoxic agents represent the largest, and fastest growing, class of oncology agents by sales volume. The following chart summarizes the value of the current oncology market. The market for products to treat cancer is changing rapidly. It is a growing market fueled by:

- Increasing disease incidence
- New product entries
- New therapeutic paradigms
- A growing adjunctive market, which increases the number of patients eligible for chemotherapy
- Intense research and competition

The increase in the aging population in developed countries increases the incidence of cancer. The diagnosed cancer incidence and prevalence in seven major markets, including the U.S., France, Germany, Italy, Spain, U.K. and Japan are close to 3 million and 10 million respectively. The numbers are increasing steadily. Currently, about one-third of the new medicines in development are targeted against cancer.

Cancer is not a single disease, but includes more than 100 different disorders, which have at their core uncontrolled cell growth. Of these disorders, the cancer types that offer the greatest commercial opportunity include breast, colorectal, lung, ovarian and prostate (based on incidence/prevalence/unmet need). Treatment of breast, lung and prostate cancers account for more than 50 percent of the direct medical costs of cancer therapies. Other cancer types, specific to one or more of the major international markets, may provide niche opportunities. For instance, stomach (gastric) cancer is relatively common in Japan but not in the U.S. or Europe; similarly, liver cancer has a greater occurrence in Japan, Italy and Spain.

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Depending on tumor type, cancer can be treated with surgery, radiation, chemotherapy (cytotoxic), hormonal therapy or a combination of any of these. For the purpose of this analysis, we will define the cancer market as chemotherapeutics and the adjunctive therapies used to counter the effects of chemotherapy and radiation therapy. The following charts summarize the global sales for these products.

Global Sales by Market Segment (\$ MM)

	1996 Sales	1997 Sales	1998 Sales	CAGR '96-'98
Hormone	4,414	4,784	4,884	5.2%
Cytotoxic	4,278	5,212	6,268	21.0%
Adjunctive	3,367	3,651	4,166	11.2%
Total	12,059	13,647	15,318	12.7%

Source: Datamonitor

Sales by Region (\$ MM)

	1996 Sales	1997 Sales	1998 Sales	CAGR '96-'98
US	5,564	6,276	7,422	15.5%
Ex- US	6,495	7,370	7,896	10.3%

Source: Datamonitor

Chemotherapeutic agents

Cytotoxic therapies include classes such as alkylating agents, anti-tumor antibiotics, anti-metabolites and antimitotics (taxanes). These agents are toxic and demonstrate dose-limiting side effects. The commercial value of this segment is significantly understated, as most of the products are available in generic form.

The growth of the cytotoxic segment in the past three years has been driven primarily by the introduction of new, more effective and expensive therapies such as Taxol (paclitaxel/BMS), Gemzar (gemcitabine/Lilly), Taxotere (docetaxel/RPR) and Hycamtin (topotecan/SB). Utilization of these newer agents, however, appears to be dependent on the cost sensitivity of the local market. For example, secondary sources indicate that Taxol has recorded over 60% of its global sales in the US market alone and is prescribed with far less frequency in the more cost sensitive UK, German and French markets.

Most chemotherapeutic agents are indicated for just one or two cancer types, but get significant off-label use once approved. Up to 60% of an oncology product's use is potentially for off-label indications. Much of this use is driven by the publication of data and/or approvals in other countries.

Hormonal therapies

Of the top-selling drugs in each major geographical region, *hormone therapies* contribute approximately one-third of the sales ex-US and one-fourth in the US. Hormone therapies for the treatment of cancer include Lupron (leuprolide/TAP), Zoladex (goserelin/Zeneca), Nolvadex (tamoxifen/Zeneca) and other agents used to treat hormone responsive diseases such as prostate and breast cancer. These agents are generally administered chronically and have reduced side effects compared to cytotoxic therapies. Sales of this category are driven primarily by Lupron and Zoladex. The US market has become increasingly cost sensitive in the Medicare sector, which accounts for over 70% of Lupron sales.

Adjunctive agents

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The availability of effective *adjunctive agents* also allows the cytotoxic chemotherapeutic agents to be administered at higher doses and/or more frequently, or used in a more palliative role, since the adjunctive therapies can reduce the impact of the chemotherapy on the patient's quality of life. Agents in this class include immunostimulants, anti-emetics and bisphosphonates. The growth of this market is linked to the growth of the cytotoxic market, as the increased use of cytotoxic agents drives an increased use in adjunctive therapy. The highest selling product in this class is Neupogen (filgrastim/Amgen) with 1998 sales of over \$1 billion.

Biologic Therapy

New therapies under development offer the promise of fulfilling several unmet needs in the treatment of cancer. Experts have predicted that in the future early therapy for breast cancer will be dominated by biological approaches, such as monoclonal antibodies (Herceptin/Genentech), which is widely thought to have strong market potential. Genentech recently reported strong second quarter sales of the product in the US of \$46.2 million, and it is estimated that if only half of US women with breast cancer who over-express this gene received Herceptin, sales would top \$600 million. In addition to monoclonal antibodies, other biological approaches include vaccines and gene therapy.

Future Trends

Emerging science in the past decade offers the potential to radically alter the paradigm for cancer therapy and presents opportunities for fundamentally new ways of approaching the disease. New therapies offer the promise of fulfilling several unmet needs in the treatment of cancer. These include matrix metalloproteinase inhibitors (MMPis), continued expansion of biologics, photodynamic therapies (PDT), anti-angiogenics, and multiple drug resistance (MDR) modifiers. This market does not yet exist, though success of "cytostatic-like" treatments, such as hormonal therapies for prostate and breast cancer, suggests that the market potential for cytostatic agents could be significant.

Competition

The angiogenesis pipeline is very competitive, but this level of intensity is somewhat skewed by the large number of mechanistic approaches that are being claimed to demonstrate angiogenic activity. Furthermore, clear evidence of efficacy for these agents has not yet been demonstrated. For the purposes of this summary, only those compounds considered true anti-angiogenic compounds have been included. Companies with compounds in clinical development include Genentech, Entremed, Sugen, TAP, Magainin and Pharmacia Upjohn.

Angiogenesis Compounds in Clinical Development

Compound	Indications	Company	Phase
Neovastat	Solid tumors	Aetema	III
RhuMab VEGF	Cancer	Genentech	II/III
Vitaxin	Arthritis, psoriasis, CVR	Ixsys	II
SU-5416	Cancer	Sugen	II/III
TNP 470	Cancer, arthritis	TAP	II
Thalidomide	Cancer	EntreMed/BMS	I
Squalamine, squalus	Cancer	Magainin	I
RPI 4610	Cancer	Ribozyme	I
VEGF antagonist	Cancer, retinopathy	NeXstar	I
Angiostatin/Endostatin	Cancer	EntreMed	I

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Unmet Needs

Cancer remains the second leading cause of death in the United States, Europe and Japan, and consequently, offers an attractive market opportunity for the pharmaceutical and biotechnology industries. This year about 563,100 Americans are expected to die of cancer, more than 1,500 people a day. In the US, 1 or 4 deaths is due to some form of cancer. In 1999, about 1,221,800 new cancer cases are expected to be diagnosed.

For most cancers, the level of physician satisfaction with current therapies is low. It has long been recognized by researchers, physicians, patients and family members that current treatment options may often be as devastating as the underlying disease.

Unmet needs in this market vary by tumor types and stages, with some tumors responding to treatment with better mortality and/or morbidity results than others. However, cancer is still treated as a terminal illness with significant shortcomings in present treatments. In general, unmet needs include:

Need	ABT-510 Attribute
Enhanced efficacy of therapeutic agents	Potential for enhanced efficacy
Reduced toxicity	Potential for reduced toxicity over current cytotoxic treatment
Improvements in drug administration	TBD
Improved target delivery of cytotoxics and novel therapeutics	Unknown
Proven outcomes data	Quality of Life and Pharmacoeconomics to be assessed

Considerations

Product Usage: Physicians have indicated that they would use anti-angiogenic agents initially in their more refractory patients, as follow-on or add-on to current best therapy (chemo or surgical). With experience and clinical evidence, they would be willing to use these agents in earlier stages of the disease, where they perceived the greatest benefit to be. Anti-angiogenesis agents are regarded as a maintenance therapy to be used in early disease or after primary therapy as a prophylactic process to prevent the spread of malignancy. Of course, their ultimate use will depend on the benefit provided, which cannot be determined until clinical trials have been completed. Efficacy evidence in humans manifested by tumor response of the magnitude seen in the preliminary dog studies would stimulate tremendous enthusiasm in the oncology community.

Product Benefits/Efficacy: Physicians are looking for improvements in time to tumor progression and prevention of metastases with cytostatic agents. There is a great deal of enthusiasm for this mechanism in the scientific and lay audience. The concept is very intuitive. Products, such as ABT-510, that promise a clinical benefit without the usual toxic trade-offs associated with current chemotherapeutic agents, will be enthusiastically received by oncologists.

Side Effects The proposed safety profile of anti-angiogenic agents may enhance usage, as the dose limiting toxicity profiles of most of the other available agents has established a much lower hurdle for demonstrating a preferred profile. However, as chronic therapy, anti-angiogenic agents may have to demonstrate a cleaner profile than cytotoxic agents do to ensure compliance.

Off-label use: Off label use accounts for between 30-60% of an oncology product's usage. Off-label use is driven by publication of clinical trial results in credible journals, listing in key compendia and/or a peer's experience with the product. Therefore, development spend for off-label use is considerably less than the spend required for regulatory approval of an indication. However, promotion of these off-label uses is limited.

Other indications: ABT-510 may be effective in other therapeutic roles, such as arthritic diseases and macular degeneration. These other indications may offer a commercial upside, through internal development or co-development/out-licensing opportunities.

Competition: While there are a relatively large number of angiogenesis inhibitors in development, it is unclear whether they will demonstrate a superior efficacy or side-effect profile vs. ABT-510. The mechanism of angiogenesis suggests that multiple anti-angiogenic approaches may be required to maximize the clinical benefit.

COGS: Initial estimates on finished cost of drug place it in the range of Lupron costs. Depending on final dosing requirements, the cost of this compound could become a significant obstacle. However, this will need to be considered in light of the pricing flexibility in the oncology market, where there is limited pricing sensitivity for products that are reimbursed. Any financial analysis will need to include royalty obligations to Northwestern University.

Dosing: There is still some uncertainty regarding the route of administration and feasible dosage forms for ABT-510. An "inconvenient" formulation leaves this product extremely vulnerable to competitors with more convenient dosage forms. A convenient dosage form, such as a monthly depot, will enhance product adoption over a less convenient form. However, the effect of the various dosage forms on product adoption will be dependent on the benefits the compound provides, side-effect profile and availability of competitive agents with more convenient dosage forms. For chronic therapy, convenience will play an important role in market penetration, given alternative agents. Although less convenient than oral therapy, parenteral therapy (depot, but not self-administered sub-cutaneous) is currently reimbursed by Medicare in the US. Over 60% of all cancer patients have Medicare as their primary healthcare coverage in the US.

Development/Regulatory: With a new class of compounds, there is not a clearly defined clinical development path or regulatory guidelines for reference. This hurdle is similar for all the competitive products, but increases the overall development risk profile for these agents. However, with several anti-angiogenic agents in late stage development, Abbott can learn from their experience.

Other Approaches: Other "cytostatic" approaches may present a competitive threat if they are used as substitutes. Due to the complexity of the pathogenesis of cancer, it is more likely that these agents will be used in combinations, but incremental benefits may become more difficult to demonstrate as the number of products and approaches multiply. This will require additional studies, as these other classes become part of standard cancer treatment. However, this threat is not unique to this compound.

Pricing: The treatment of cancer is expensive, so there is the potential for a great deal of pricing flexibility in this market. There is also an increasing emphasis on cost-effectiveness studies that will need to be addressed in the development plan.

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ABT - 518

Descriptive Memorandum

February 2001

Abbott Laboratories

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MMPi**Overview**

Abbott's Matrix Metalloproteinase Inhibitor (MMPi) program represents a novel therapeutic class, with the potential to alter the way that cancer is treated by preventing or modifying disease progression and/or metastases. This more "chronic" approach to therapy has the potential to transform cancer into a disease that patients live with, much like the effect of HIV protease inhibitors on patients with AIDS. It also has the potential to expand the cancer market significantly by increasing the average length of treatment and expanding the pool of patients eligible to receive therapy.

The MMPs comprise a family of enzymes that degrade a wide range of matrix protein substrates. High expression of these enzymes occurs in cancer and is associated with the ability of tumors to grow, invade, develop new blood vessels and metastasize.

MMP inhibitors (MMPis) may suppress the progression of tumors by several mechanisms:

- Suppress invasion/metastasis by blocking the membrane traversal and access to blood/lymphatic vessels
- Blocking the remodeling of extra-cellular matrix in the vicinity of primary tumors to prevent stroma-bound growth factors from stimulating tumor growth
- Blocking angiogenesis by preventing the proliferation and migration of endothelial cells and neovascularization of tumor.

Experimental evidence suggests that gelatinase A and gelatinase B are particularly important in tumor progression, consequently the project team has targeted gelatinase selective inhibitors for the treatment of cancer. Another reason for targeting highly gelatinase-selective MMP inhibitors relates to the side effect profile exhibited by broad-spectrum agents like marimastat. Chronic administration of marimastat causes a dose-limiting side-effect characterized by severe joint pain and stiffness. Since these joint effects may be mediated by inhibition of other MMPs like fibroblast collagenase, highly gelatinase selective agents may be efficacious without producing dose-limiting side effects.

The MMP selectivity profile exhibited by ABT-518 distinguishes it from competitor's compounds. ABT-518 possesses sub-nanomolar inhibition potencies versus both gelatinase A and gelatinase B and is substantially more selective for the inhibition of the gelatinases over fibroblast collagenase than marimastat and prinomastat. Despite its high selectivity, ABT-518 demonstrates antitumor activity equal or superior to prinomastat. Inhibition of tumor growth is dose dependent in both syngeneic and xenograft models. ABT-518 is also effective in blocking vessel formation in a mouse model of angiogenesis. ABT-518 is a stable crystalline solid which can be synthesized in six steps (25% overall yield) from commercial starting material.

ABT-518 gives rise to sustained plasma concentrations following single oral dosing in monkeys, dogs and rats. Bioavailabilities range between 68 and 93% depending on formulation and species. Several metabolites are produced after repeated oral dosing of ABT-518, although their relative amounts varies with gender and species.

ABT-518 displays no meaningful effects in genotoxicity, cytotoxicity and ligand binding assays and its cardiovascular effects in dogs are unremarkable. ABT-518 produces no significant toxic effects in rats treated with 100 mg/kg/day over 28 days. Plasma concentrations generated by ABT-518 in these studies are at least 20-fold higher than those necessary to produce efficacy in cancer animal models. ABT-518 is therefore a compelling development candidate with the potential to

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demonstrate antitumor effects superior to the MMP inhibitors currently undergoing clinical trials. Phase 1 clinical trials in cancer patients began March 2001.

The market

Currently, cytotoxic agents represent the largest, and fastest growing, class of oncology agents by sales volume. The following chart summarizes the value of the current oncology market.

Global Sales by Market Segment (\$ MM)

	1996 Sales	1997 Sales	1998 Sales	1999 Sales (est)	CAGR '96-'98
Hormone	4,414	4,784	4,884	5,000	5.2%
Cytotoxic	4,278	5,212	6,268	7,300	21.0%
Adjunctive	3,367	3,651	4,166	4,900	11.2%
Total	12,059	13,647	15,318	17,200	12.7%

Source: Datamonitor

Sales by Region (\$ MM)

	1996 Sales	1997 Sales	1998 Sales	1999 Sales (est)	CAGR '96-'98
US	5,564	6,276	7,422	8,500	15.5%
Ex- US	6,495	7,370	7,896	8,700	10.3%

Source: Datamonitor

Cytostatic agents have the potential to alter the way cancer is treated and presents opportunities for fundamentally new ways of approaching the disease. This cytostatic market does not yet exist, though success of more cytostatic "like" treatments, such as hormonal therapies for prostate and breast cancer, suggest that the market potential for cytostatic agents could be significant.

The ultimate commercial and clinical success of the MMPI will depend on the clinical benefit this product provides in key cancer types compared with current best therapy. These can be benefits provided by dosing this agent in addition to current therapy and/or as an alternative to best therapy, or as a new component of best therapy. All currently available products, including the market leaders such as Taxol, have significant shortcomings in their profiles.

However, as novel therapy, MMPIs will probably be adopted initially as add-on the current chemotherapy. As benefits are proven and clinical experience is gained, these agents may be used in earlier stages of cancer and/or in conjunction with surgery or radiation to prevent the progression of any microscopic disease that remains.

The clinical targets identified for this compound include late stage pancreatic cancer, late stage NSCL cancer (on-label), with late stage ovarian and breast cancer as additional cancer types where efficacy has been demonstrated, but not filed. Other cancer types this compound may be efficacious in include SCL, colorectal, bladder, stomach and prostate. Targets will be refined as we know more about this compound's in-vivo activity.

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The following tables summarize the key marketed competitive products by indication (US data only):

Late Stage Breast	
Product	Share
Cyclophosphamide/Cytoxan/BMS	18.7
Doxorubicin/Adriamycin/P&U	17.11
Docetaxel/Taxotere/RPR	16.25
Paclitaxel/Taxol/BMS	16.11
Trastuzumab/Herceptin/Genetech	11.26

Late Stage NSCL	
Product	Share
Carboplatin/Paraplatin/BMS	50.32
Paclitaxel/Taxol/BMS	44.14
Vinorelbine/Navelbine/Glaxo	22.78
Gemcitabine/Gemzar/Lilly	22.14
Cisplatin/Platinol/BMS	11.28

Late Stage Ovarian	
Product	Share
Paclitaxel/Taxol/BMS	47.11
Carboplatin/Paraplatin/BMS	45.42
Topotecan/Hycamtin/SKB	22.54
Dox SL/Doxil/Alza	9.14
Cisplatin/Platinol/BMS	7.58

Late Stage Pancreas	
Product	Share
Gemcitabine/Gemzar/Lilly	78.5
5-FU/Efudex/ICN Pharma	21.0
Leucovorin/	10.7
Cisplatin/Platinol/BMS	4.72

Compounds in Development

The MMP inhibitor field is competitive. More than 30 firms have filed patents claiming small molecule MMP inhibitors over the past 5 years, and several companies have compounds in advanced clinical development. Abbott's compound may be 3rd or 4th to market and will have to demonstrate a competitive advantage to gain the share necessary to support the clinical development of this compound. Companies with compounds in advanced clinical development for the treatment of cancer include Agouron/Warner Lambert/Pfizer, British Biotechnology/Schering Plough and BMS and are listed below. Other companies are targeting this mechanism for arthritis.

MMPis in Clinical Development for Cancer

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Compound	Company	Comments	Phase
Marimistat	BritishBiotechnology/ Schering Plough	Broad spectrum, dose limiting toxicity. Activity seen in gastric cancer, but negative results in pancreatic.	III
Prinomastat	Agouron/ Warner Lambert/ Pfizer	Moderate gelatinase selectivity, dose limiting toxicity. May be dosing sub-optimally to avoid toxicity. Efficacy data not available.	III
BMS 275291	BMS	Broad spectrum, joint effects seen in Phase I studies.	II

Bayer recently dropped development of BAY 12-9566 due to concerns about potential toxicity. Recent results from a study with marimistat in pancreatic cancer, where adding marimistat to Gemzar resulted in no survival advantage, has led to speculation that MMPs may be more applicable in less aggressive cancer types or earlier stages of the disease. Alternatively, it could be a reflection of the inability to examine higher doses of marimastat due to joint effects.

The joint effects produced by the compounds listed above almost certainly preclude their long-term use, limit compliance and reduce optimal efficacy. Any MMP inhibitor that lacks these side effects will possess a substantial competitive advantage. The musculoskeletal effect produced by marimastat and prinomastat in cancer patients is typically described as arthralgia, myalgia and tendinitis, which occurs predominately in the upper limbs. While mild cases respond to analgesics, interrupting therapy for a period of approximately 2 weeks is necessary when the condition is less well tolerated.

Although Abbott's timing to market is not optimal, the shortcomings of the competitive products provide an opportunity for a compound with an improved SE or efficacy profile. Current animal models seem to predict Abbott's compound is superior to those currently in clinical trials, and has the potential to be best in class.

Product profile

The objective of a product profile at this time in the product's development is to provide a target for the types of attributes that will be required to be commercially successful. This profile is based on market research with oncologists and consultation with opinion leaders. This profile will continue to be refined as more is known about this product's profile, development of competitive products and the market continues to evolve.

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	Base	Optimal
Efficacy	ABT-518, alone or in combination with best therapy, provides at least one of	Provides more than one of the efficacy benefits outlined.

	<p>the following benefits in at least one solid tumor type:</p> <ul style="list-style-type: none"> • Increased survival • Tumor regression • Improved quality of life • Increased time to tumor/disease progression 	
Competitive advantage	ABT-518 will need to demonstrate a clinically significant advantage in efficacy (see parameters above) or additive synergistic activity with current/competitive agents or clinically significant advantage in side-effect profile relative to other MMPI agents.	Same
Administration	Convenient administration relative to competitive agents.	Same plus reimbursement in US market.
COGS	A finished cost of goods that is consistent with at least an 80% standard manufacturing margin.	A finished cost of goods that is consistent with at least a 90% standard manufacturing margin.

Marketing overview

Product Usage: Physicians have indicated that they would use MMPIs initially in their more refractory patients, as follow-on or add-on to current best therapy (chemo or surgical). With experience and clinical evidence, they would be willing to use these agents in earlier stages of the disease, where they perceived the greatest benefit to be. The MMPI was regarded as a maintenance therapy to be used in early disease or after primary therapy as a prophylactic process to prevent the spread of malignancy.

Product Benefits/Efficacy: Physicians are looking for improvements in time to tumor progression and prevention of metastases with cytostatic agents. The MMPI mechanism has more recently been implicated as having an even more active role in cancer pathogenesis, from preventing primary tumor growth to anti-angiogenic properties. Positive results from competitive agents, such as marimistat in gastric cancer, provides proof of principle for this mechanism.

Side Effects: The proposed safety profile of MMPIs (excluding joint toxicity) may enhance usage, as the dose limiting toxicity profiles of most of the other available agents has established a much lower hurdle for demonstrating a preferred profile. However, as chronic therapy, MMPIs may have to demonstrate a cleaner profile than cytotoxic agents do to ensure compliance. As the 3rd or 4th MMPI to market, SE hurdles will be even higher for this compound. As a critical Go/No Go decision point, the joint toxicity of this compound will be evaluated in an expanded Phase I multi-dose study.

Dosing: Discovery is currently targeting an oral dosage form. In general, oral therapies are acknowledged by physicians and patients as being more convenient to the patient. Chronic oral dosing may also reduce overall costs, as infusion support products and personnel would not be required, enhancing pharmacoeconomic evidence.

COGS: Initial estimates on finished cost of drug suggest that drug costs will not be significant for this compound

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Off-label use: Off label use accounts for between 30-60% of an oncology product's usage. Off-label use is driven by publication of clinical trial results in credible journals, listing in key compendia and/or a peer's experience with the product. Therefore, development spend for off-label use is considerably less than the spend required for regulatory approval of an indication. However, promotion of these off-label uses is limited.

Competition: As the 3rd or 4th MMPi to market, Abbott's compound will need to demonstrate a meaningful clinical advantage over compounds that are in more advanced development. Strict Go/No Go criteria will determine if the MMPi can meet these hurdles. If they cannot be met, the compound will not move forward.

Development/Regulatory: With a new class of compounds, there is not a clearly defined clinical development path or regulatory guidelines for reference. This hurdle is similar for all the competitive products, but increases the overall development risk profile for these agents. However, with several MMPis in late stage development, Abbott can learn from their experience.

Other Approaches: Other "cytostatic" approaches may present a competitive threat if they are used as substitutes. Due to the complexity of the pathogenesis of cancer, it is more likely that these agents will be used in combinations, but incremental benefits may become more difficult to demonstrate as the number of products and approaches multiply. This will require additional studies, as these other classes become part of standard cancer treatment. However, this threat is not unique to this compound.

Pricing: The treatment of cancer is expensive, so there is the potential for a great deal of pricing flexibility in this market. However, as an oral therapy in the US market, there may be additional downward price pressure for this agent. There is also an increasing emphasis on cost-effectiveness studies that will need to be addressed in the development plan.

Dosing: Discovery is currently targeting an oral dosage form. In general, oral therapies are preferred by physicians and patients because of the convenience to the patient. However, this form may not be the best choice for some people who already have certain digestive system symptoms (vomiting, diarrhea, or severe nausea), cannot swallow liquids or pills, or cannot remember when or how many pills to take. Additionally, in the US market there are several unique factors that currently do not favor oral therapies. Novel oral therapies are not currently reimbursed by Medicare, a significant payer for the oncology patient population. Also, 40-60% of a community oncologist's income is generated through the administration of IV drugs. An oral therapy would not be a source of revenue to the physician.

Clinical Studies

Clinical studies across a wide range of solid tumors will be initiated, including but not limited to breast cancer, non small cell lung cancer, ovarian cancer, pancreatic cancer, etc....

Final indications pursued will depend from the results of the phase II studies.

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Farnesyltransferase Inhibitor

Descriptive Memorandum

February 2001

Abbott Laboratories

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Overview

The Ras genes were the first oncogenes of mammalian origin to be discovered. Intensive research over the last decade has led to the elucidation of the normal function of cellular Ras protein, the role of Ras mutations in oncogenic transformation, and the identification of molecular targets, such as the enzyme farnesyltransferase, for inhibiting Ras activity. Although farnesyltransferase inhibitors (FTIs) were initially designed with the intention of inhibiting the posttranslational prenylation, and hence function, of Ras, it is now becoming apparent that farnesylated proteins other than Ras (e.g., RhoB) are also critical for malignant growth and may be the relevant target for inhibition of farnesylation. While it remains controversial whether blocking Ras activity or altering the RhoB prenylation status is the actual function of an FTI, these agents, exemplified by ABT-839 and FTIs in the clinic, exhibit remarkable anticancer activity against a wide variety of tumors in preclinical models. The current FTI program is projected to reach DDC status in January, 2001.

Abbott evaluated one FTI, ABT-839, in normal volunteers, but decided to discontinue development of this drug due to its poor pharmacokinetic profile. Invaluable experience was gained, however, from both the preclinical and clinical studies with this compound. Abbott's second-generation series are novel structures that exhibit significantly improved potency and oral bioavailability.

There continues to be tremendous enthusiasm in the medical community and pharmaceutical industry for this mechanism of action. Farnesyltransferase inhibitors have demonstrated impressive antitumor activity in preclinical models with activity equivalent to or better than that achieved with conventional cytotoxic chemotherapy given at the maximal tolerated dose. These agents appear to inhibit angiogenesis and, consistent with this activity, minimal resistance has been observed in preclinical models. The potential also exists for synergistic activity in combination with cytotoxic chemotherapy.

The market

Cancer remains the second leading cause of death in the US, and consequently is an attractive market opportunity for the pharmaceutical/biotechnology industries. Approximately 40% of all Americans will develop cancer in their lifetime.

The worldwide cytotoxic and hormonal cancer therapies market is highly fragmented with only BMS and Zeneca holding a greater than 10% market share. Although the market is not concentrated, the field is highly competitive with more than 60 companies focused on the cancer research area. The growth of the oncology market is fueled by increasing disease incidence, new product entries, new therapeutic approaches, a growing adjunct therapy market that expands the number of patients eligible for chemotherapy, and intensified research competition. The data in Tables 1 and 2 summarize the value of the current oncology market. A great deal of uncertainty surrounds the concept of cytostatic treatment of cancer. Conceptually it may transform the way cancer is treated, allowing patients longer disease free survival and improved quality of life. However, at this point in development, this paradigm does not exist in cancer. Considering market, clinical and patient dynamics factors, breast, colorectal, prostate and non-small cell lung cancers are the most attractive targets for development.

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Table 1. Global sales by market segment (\$ MM)

	1996 Sales	1997 Sales	1998 Sales	1999 Sales (est.)	CAGR '96-'98
Hormone	4,414	4,784	4,884	5,000	5.2%
Cytotoxic	4,278	5,212	6,268	7,300	21.0%
Adjunctive	3,367	3,651	4,186	4,900	11.2%
Total	12,059	13,647	15,318	17,200	12.7%

Source: Datamonitor

Table 2. Sales by region (\$ MM)

	1996 Sales	1997 Sales	1998 Sales	1999 Sales (est.)	CAGR '96-'98
US	5,564	6,276	7,422	8,500	15.5%
Ex- US	6,495	7,370	7,896	8,700	10.3%

Source: Datamonitor

Cytostatic agents have the potential to alter the way cancer is treated and presents opportunities for fundamentally new ways of approaching the disease. This cytostatic market does not yet exist, though success of more cytostatic "like" treatments, such as hormonal therapies for prostate and breast cancer, suggest that the market potential for cytostatic agents could be significant.

The ultimate commercial and clinical success of the FTI will depend on the clinical benefit this product provides in key cancer types compared with current best therapy. These can be benefits provided by dosing this agent in addition to current therapy and/or as an alternative to best therapy, or as a new component of best therapy. All currently available products, including the market leaders such as Taxol, have significant shortcomings in their profiles.

However, as novel therapy, FTIs will probably be adopted initially as add-ons to current chemotherapy. As benefits are proven and clinical experience is gained, these agents may be used in earlier stages of cancer and/or in conjunction with surgery or radiation to prevent the progression of any microscopic disease that remains.

The clinical targets identified for this compound include late stage pancreatic cancer, late stage NSCL cancer (on-label), with late stage ovarian and breast cancer as additional cancer types where efficacy has been demonstrated, but not filed. Other cancer types this compound may be efficacious in include SCL, colorectal, bladder, stomach and prostate. Targets will be refined as we know more about this compound's in-vivo activity.

The following tables summarize the key marketed competitive products by indication (US data only):

Late Stage Breast	
Product	Share
Cyclophosphamide/Cytoxan/BMS	18.7
Doxorubicin/Adriamycin/P&U	17.11
Docetaxel/Taxotere/RPR	16.25
Paclitaxel/Taxol/BMS	16.11
Trastuzumab/Herceptin/Genetech	11.26

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Late Stage NSCL	
Product	Share
Carboplatin/Paraplatin/BMS	50.32
Paclitaxel/Taxol/BMS	44.14
Vinorelbine/Navelbine/Glaxo	22.78
Gemcitabine/Gemzar/Lilly	22.14
Cisplatin/Platinol/BMS	11.28

Late Stage Ovarian	
Product	Share
Paclitaxel/Taxol/BMS	47.11
Carboplatin/Paraplatin/BMS	45.42
Topotecan/Hycamtin/SKB	22.54
Dox SL/Doxil/Alza	9.14
Cisplatin/Platinol/BMS	7.58

Late Stage Pancreas	
Product	Share
Gemcitabine/Gemzar/Lilly	78.5
5-FU/Efudex/ICN Pharma	21.0
Leucovorin/	10.7
Cisplatin/Platinol/BMS	4.72

Emerging science within the past decade has radically altered the paradigm for cancer therapy and presents opportunities for fundamentally new ways of approaching the disease. Abbott has multiple discovery cytostatic targets, which may improve effective, but we are not alone: more than 200 compounds from other players are in development. The goal of cytostatic therapy is to improve quality of life, controlling the disease and transforming aggressive treatment to a chronic condition, which has been compared to the impact of protease inhibitors on the course of HIV.

Clinical Studies

Considering all the factors, market, clinical and patient dynamics, breast, colorectal, prostate and non-small cell lung cancer appear to be the most attractive targets for development. The development of cytostatic agents faces a number of challenges as regulatory agencies and physicians evaluate the new emerging paradigm of cancer therapy.

Despite the enormous medical need, drugs for chronic treatment/disease stabilization and improved quality of life for cancer patients do not yet exist. Correspondingly, animal models test efficacy that has not yet been validated as predictive of response in humans. Medical oncologists have historically depended on determination of maximum tolerated dose and response manifested by tumor shrinkage for cancer drug development. These parameters are not relevant to novel "cytostatic" agents. Combination with conventional cytotoxic drugs will be required in the near term and will have to be determined empirically. Intermediate and surrogate measures of biological response will have to be developed. Regulatory agencies are grappling with the same issues.

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Competition:**Within Project Approach**

Company	Compound	Indication	Status of compound	Status of project
Janssen Pharmaceutica	R-11577 (A-251076)	Cancer (unspecified)	Phase III	active
Schering-Plough	Sch66336 (A-285622)	Cancer (unspecified)	Phase II	active
Merck	L-778123	Cancer (unspecified)	Phase I (I.V.) abandoned	unknown
Bristol-Myers Squibb	BMS-214662	Cancer (unspecified)	Phase I	active
LG Chemical	LB 42908	Cancer (unspecified)	preclinical	active
Rhône-Poulenc Rorer	quinuclidine derivatives	Cancer (unspecified)	preclinical	active
Pfizer	unknown structure	Cancer (unspecified)	preclinical	active
Parke-Davis	unknown structure	Cancer (unspecified)	preclinical	abandoned project
Roche	peptidomimetics	Cancer (unspecified)	preclinical	abandoned project
Elsal	peptidomimetics	Cancer (unspecified)	preclinical	unknown
Banyu	FPP mimetic	Cancer (unspecified)	preclinical	active
ISIS	ISIS-2503 (ras antisense)	Cancer (unspecified)	Phase I	active

Within Therapeutic Area

Approach	Selected Compounds	Company(ies)	Status
antisense	ISIS 3521, ISIS, 5132	ISIS	phase I
cytotoxic agents	camptothecin, CI-980, farestroin, Genzar, Hycamtin, Irinotecan, Novantrone, Onconase, Capecitabine, Tomudex	P&U, Warner-Lambert, Schering, Lilly, SKB, P&U, Immunex, Alkermes, Roche, Zeneca	most phase III
differentiation	targetin, panretin, 5-azacytidine	Ligand, HCl	Ligand in phase III
drug resistance modifiers	VX-710, 776C85, RMP-7, CT-2584	Vertex, Glaxo Wellcome, Alkermes, Cell Therapeutics	Vertex in phase II
gene therapy	Onyx-015, MDX1, GLI-328, IL-2, GV-1301	Onyx, Introgen, Therion Biologics, Theragen, Genetic Therapy, Cyclacel, RPR GenCell, GeneMedicine, Titan, etc	Restricted to accessible cancers. Most advanced: Phase VII
hormonal therapy	Zolodex, amide, droloxien, Oncolar, Rivotar, Casodex, roglatamide	Zeneca, Pfizer, Novartis, Janssen, US bioscience	most phase III
immunotherapy antibodies	IDEC-Y2A2B8, anti-HER2, anti EGFR	IDEC, Genetech, ImClone	IDEC recently approved, others phase III
cytokines	IL-12, IL-4, Proleukin, Roferon-A	Roche, Schering, Chiron, Roche	phase III
vaccines	IV-gp100, Genevax, MGv	Apollon, Therion, Progenics	phase I, II
photodynamic	photofrin, promycin	OLT photo, Vion	phase III
radiation sensitizers	Neu-Sensamide, radinyl	Oxigene, Roberts	phase II, III
metalloproteinase inhibitors	marimastat, AG-3340, CGS-27023A	British Biotech, Agouron, Novartis, Bayer	BBT in phase III
angiogenesis inhibitors	TNP-470, SU-5416, anti VEGF-mAb, thalidomide, DC101	TAP, Sugen, Genentech, Entrened, ImClone, etc	see angiogenesis project review for details

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Competitive Analysis

The project is on par with others in the industry. While second generation Abbott compounds are not yet in clinic, all of the compounds from other companies that are in clinical trials have deficiencies. While the Schering compound has the best oral PK profile, it is not particularly potent. The Janssen compound is potent, but has a poor PK profile. The Merck compound exhibited QTc prolongation and development has been stopped. The Bristol Myers Squibb compound, BMS-214662, which is in phase I, is an *in vitro* submicromolar inducer of apoptosis in human tumor cells and appears to be the most potent inducer of apoptosis of the known FTIs. This compound could have a different mechanism of action from the classical FTIs and have its own liabilities. LG42908 from LG Chemical is potent FTI and has good oral bioavailability (F=91% in monkey), however, it's a CYP3A4 inhibitor and will have significant drug-drug interaction liabilities. Extensive preclinical pharmacology at Abbott has defined optimum parameters for a FTase inhibitor that may not be known to our competitors, or be achievable with the current generation of FTIs. Although not yet established, we anticipate that the Abbott compound will be improved over competitors' compounds with respect to potency, oral bioavailability, half-life, toxicity, efficacy, angiogenesis inhibition, and lack of resistance.

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**DOPAMINE RECEPTOR AGONIST
PROGRAM**

Descriptive Memorandum

February 2001

Abbott Laboratories

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JH 008206**

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D4 Agonists for Male Erectile Dysfunction

Scientific Overview

Male erectile dysfunction (MED) is defined as the "inability to maintain an erection sufficient for satisfactory sexual intercourse" (NIH Consensus Panel) and results from physiological (organic), psychogenic causes, or a combination thereof. This disorder is associated with decreased quality of life, including personal well being, and diminished family and social relationships. In 1999, an estimated 77 million men over the age of 40 (52% of men over 40 years-old) in the seven major pharmaceutical markets experienced some degree of MED, and the prevalence increases with age. Approximately 10-20% of patients have severe or complete MED, and the majority of the population suffers from moderate disease. While the introduction of Viagra has increased the diagnosis rate of MED in the U.S., 75% or more of patients do not seek treatment. However, as the "baby boomer" generation ages, MED will become a more prominent concern and a growing number of patients are likely to seek treatment.

Abbott's male erectile dysfunction program targeting D4 dopamine receptors represents a novel therapeutic approach to the rapidly growing male erectile dysfunction (MED) market. The current gold standard for the treatment of MED, Viagra, acts peripherally at the penile smooth muscle level to induce erection by modulating the levels of cGMP. In contrast, a selective D4 dopamine agonist will act in the brain at the sites necessary for initiation of a successful erection. Targeting the D4 receptors in brain offers the potential for efficacy in patients with MED that do not respond to Viagra (for example patients with diabetes). Additionally, targeting D4 receptors should not result in any cardiovascular adverse events unlike Viagra which can cause serious cardiovascular effects in patients who are on nitroglycerine-based medications. Since safety is of paramount importance for any life-style disorder like MED, a new agent that does not have any contraindications or warnings related to safety issues may be positioned to become the gold-standard therapy.

Evidence for the potential of a selective D4 dopamine receptor agonist for the treatment of erectile dysfunction includes:

- The non-selective dopamine receptor agonist apomorphine (Uprima™) has been shown to be effective in phase III clinical trials, and has received scientific approval for market in the EU, for the treatment of MED. This validates the utility of dopaminergic agonists to facilitate penile erections in humans. However, the clinical development of apomorphine for the US market has been hampered by dose limiting side-effects (emesis and syncope).
- Studies at Abbott have established that the efficacy of apomorphine (penile erection) and side-effect (emesis) are mediated by different dopamine receptor subtypes. There are 5 known dopamine receptors. Abbott scientists have discovered that the selective activation of D₄ receptors can facilitate penile erection in animals, while the D₂ receptor appears to mediate the emetic effect of apomorphine. The discovery of a D₄ selective agonist maximizes the possibility to identify a compound with equivalent/superior efficacy to apomorphine but devoid of its side-effect liabilities.

PPD is currently screening the Abbott library of compounds to identify novel and proprietary D4 dopamine receptor compounds. Initial hits have been identified that are as potent as any known D4 dopamine receptor agonist. The strategy is to aggressively profile these hits for selectivity across the five different dopamine receptor subtypes and to ensure that selective agents are effective in a number of preclinical in vivo models of MED and have no emetic or cardiovascular side effects. The D4 dopamine receptor agonist program will be discontinued if selective D4 agonists do not achieve at least a 30-fold separation between efficacy in a model of MED and cardiovascular/emetic side effects.

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Abbott has a competitive advantage in the race to exploit selective D4 dopamine receptor agonists for MED. A patent application covering the use of any selective D4 agonist for the treatment of MED has been filed and no other pharmaceutical company may have the range of preclinical models of efficacy and safety in addition to access to the clinical information gained from the development of apomorphine. Our molecular modeling group has facilitated advances in the design of selective D4 agonists.

Market Analysis

The introduction of Viagra combined with increased disease awareness resulted in the MED market in the US exploding from \$157MM in 1997 to an estimated \$726MM in 2000. Worldwide, this market has seen similar growth, and is estimated at \$500MM for ex-US for 2000. Viagra currently dominates the MED market, with more than \$1 billion in sales in the \$1.3 billion worldwide market in 1999, and >95% of the MED prescriptions in the US. The market growth is expected to continue, with an estimated CAGR in the US of 17.9% (2000 – 2005), fueled by increased awareness of MED, expanded use to wider patient segments for relationship or performance enhancement, and the introduction of heavily promoted new agents. Downward pressure on growth will come from continued perceptions of safety concerns, the limited efficacy of Viagra™, and out-of-pocket cost to patients.

Market drivers influencing the potential of a D4 dopamine receptor agonist include:

- Patient Awareness and Demand Viagra has built considerable awareness of MED. However, in the US, only 10-25% of current MED patients seek treatment for this disorder. Ex-US the percentage of patients seeking treatment is lower (10%). This is mainly due to the lack of DTC promotional campaigns in the ex-US markets. Further market expansion requires continued patient and physician education.
- Product Safety: There are growing patient and regulatory concerns regarding the safety of Viagra. While, physicians currently perceive Viagra™ to be safe, if used by the correct patients, there is significant concern regarding the concomitant use of nitrates for cardiovascular disorders with Viagra. Approximately 10% of Viagra patient deaths have been attributed to use of nitrates. Thus, there is an opportunity to eliminate this concern for physicians and to expand the market.
- Product Efficacy: In clinical trials Viagra allowed successful intercourse in about 50% of attempts. The limited and inconsistent efficacy of the product has resulted in patient dissatisfaction and discontinuation, thus creating a chance to drive Viagra quitters or switchers, as well as new patients, to new, more effective, MED products. The demonstration of efficacy in a broader population of MED patients might also influence physicians to try an alternative product prior to Viagra. The delay in onset (~1hr) and the variability in onset of action from patient to patient is an additional complaint about Viagra. Product features of a selective D4 agonist such as a more rapid onset of action or more reproducible onset will have a positive influence on the market opportunity for MED therapies.
- Additional Indications: Use of a D4 dopamine receptor agon in other indications such as "relationship enhancement" (female sexual dysfunction and age-related decline in male sexual performance) offers an opportunity to both expand the potential market to include women and non-MED sufferers, and reduce the embarrassment of MED for patients. Additional research is required to identify meaningful endpoints in this expanded indication. Initial studies conducted by Pfizer showed that Viagra™ was not effective to treat female sexual dysfunction.

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Competitive Overview

The following tables summarize the key competitive activities in regard to marketed products and products in the development pipeline. To date there are no reports any other company targeting selective D4 agonists for the treatment of MED, although a number of companies do have activities in the dopamine receptor arena for other indications that could be re-focused to MED if they became aware of Abbott's insights into the D4 receptor.

A. Oral agents

Approach	Compound/Product	Company(ies)	Status
PDE5 inhibition	Sildenafil (Viagra TM)	Pfizer	Marketed
DA receptor	Apomorphine (Uprima TM)	TAP	NDA filing withdrawn
Adrenergic	Phenolamine (Vasomax TM)	Schering-Plough/Zoragen	NDA filing on hold (>1 year)
PDE5 inhibition	IC351 (Cialis TM)	ICOS-Lilly	Phase III
PDE5 inhibition	Vardenafil	Bayer	Phase II-III

B. Intranasal

Approach	Compound/Product	Company(ies)	Status
DA receptor	Nasal apomorphine	Nasotech	Phase II

C. Intracavernosal agents

Approach	Compound/Product	Company(ies)	Status
EP receptor	PGE ₁ (Caverjet TM , Edex TM)	Pharmacia, Schwarz Pharma	Marketed
VIP receptor/ Adrenergic	VIP-phenolamine (Invicorp TM)	Senetek	Marketed outside US
K channels	PNU 83757	Pharmacia	Phase II

D. Intraurethral agents

Approach	Compound/Product	Company(ies)	Status
EP receptor	PGE ₁ (Muse TM)	Vivus, Abbott	Marketed

E. Topical

Approach	Compound/Product	Company(ies)	Status
EP receptor	PGE ₁ (Alprox-TD; Topiglan)	NexMed; MacroChem	Phase II and III

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March 13, 2001

John Hancock Life Insurance Company
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John Hancock Variable Life Insurance Company
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Boston, MA 02117

Ladies and Gentlemen,

I have acted as counsel for Abbott Laboratories, an Illinois corporation (the "Company"), in connection with the Company's collaboration with John Hancock Life Insurance Company, a Massachusetts corporation, Investors Partner Life Insurance Company, a Massachusetts corporation, John Hancock Variable Life Insurance Company, a Delaware corporation (collectively, "John Hancock") pursuant to the Research Funding Agreement made as of March 13, 2001 (the "Research Funding Agreement"). Capitalized terms used herein without definition have the meanings assigned to them in the Research Funding Agreement.

In connection with the opinions expressed herein, I have made such examination of matters of law and of fact as I considered appropriate or advisable for purposes hereof. As to matters of fact material to the opinions expressed herein, I have relied upon certificates and statements of government officials and of officers of the Company. I have also examined originals or copies of such corporate documents or records of the Company as I have considered appropriate for the opinions expressed herein. I have assumed for the purposes of this opinion the genuineness of all signatures (other than those of individuals signing on behalf of the Company which are genuine), the legal capacity of natural persons, the authenticity of the documents submitted to me as originals, the conformity to the original documents of all documents submitted to me as certified, facsimile or photostatic copies, and the authenticity of the originals of such copies.

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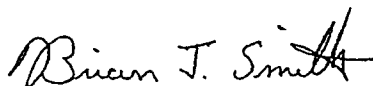
John Hancock Life Insurance Company
Investors Partner Life Insurance Company
John Hancock Variable Life Insurance Company
March 13, 2001
Page 2

Based upon the foregoing, and subject to the qualifications and limitations stated herein, I am of the opinion that: (i) the Company is duly organized, validly existing and in good standing in the State of Illinois; (ii) the Company has the requisite corporate power and authority to execute, deliver and perform the Research Funding Agreement; (iii) the Research Funding Agreement has been duly and validly authorized by the Company, and duly executed and delivered by an authorized officer of the Company and constitutes a valid and binding legal obligation of the Company enforceable against it in accordance with its terms; (iv) the performance of the Research Funding Agreement by the Company does not constitute a breach or violation of its organizational documents or any other agreement or understanding, written or oral, to which the Company is a party or any existing law, statute, rule or regulation by which the Company is bound; (v) no consents or approvals of any court or governmental authority is required on the part of the Company in connection with the execution, delivery, and performance of the Research Funding Agreement; (vi) there is no litigation pending, or to my knowledge threatened, which calls into question the validity of the Research Funding Agreement.

My opinion expressed above is limited to the law of the State of Illinois and the federal law of the United States, and I do not express any opinion herein concerning any other law.

The opinion set forth herein is rendered only to you and solely for your benefit in connection with the above described transactions. This opinion may not be relied upon by you for any other purpose, or relied upon by any other person for any purpose, without my prior written consent.

Very truly yours,



Deposition Exhibit 5

P's Exhibit SN

**Portfolio Review Meeting
March 7 – 9, 2001
The Hyatt Deerfield**

Wednesday, March 7

7:30 am	Welcome/ introduction	10 min		J. Leiden
7:40 am	Meeting objectives	10 min		J. Leonard
	Anti-Infectives	Presentation	Discussion	
	Quinolones			
7:50 am	- ABT- 492	20 min	5 min	C. Craft
8:15 am	- HSR- 903	30 min	10 min	T. Hirose/R. Krautheimer
	Anti-virals			
8:55 am	Triangle projects	30 min	10 min	M. Heath-Chiozzi
	- HIV and HBV (FTC; DAPD)			
9:35 am	Morning Break			
	Urology			
9:55 am	BSF 420627 (ETA/ BPH)	30 min	10 min	M. Kirchengast
	T3/T4			
10:35 am	T3/T4	15 min	5 min	C. Schreiber/T. Miller
	Asthma			
10:55 am	Hokunalin tape	15 min	5 min	T. Hirose/R. Krautheimer
	Oncology			
11:15 am	ABT-510	20 min	15 min	P. Nisen
11:50 am	ABT-751	20 min	15 min	P. Nisen
12:25 pm	Lunch			
1:25 pm	ABT-518	15 min	5 min	P. Nisen
1:45 pm	Rubitecan	20 min	5 min	P. Nisen
2:10 pm	Theragyn	20 min	5 min	P. Nisen
2:35 pm	ABT-627	30 min	10 min	P. Nisen
3:15 pm	Afternoon Break			
	Cardiology			
3:35 pm	Darusentan (LU 135252) LU208075	45 min	10 min	M. Luz/M. Kirchengast M. Luz/M. Kirchengast
	Thrombosis			
4:30 pm	PEG-hirudin	30 min	10 min	V. Ifthekar/U. Legler
5:10 pm	Anecrod	30 min	10 min	D. Levy/U. Legler
5:50 pm	Urokinase/ Pro-urokinase	30 min	10 min	S. Gupta

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Leiden EXHIBIT 5
FOR I.D. 4-26-07 *[Signature]*

**Portfolio Review Meeting
March 7 – 9, 2001
The Hyatt Deerfield**

Thursday, March 8

Neuroscience

		Presentation	Discussion	
7:30 am	ABT 594	30 min	10 min	B. McCarthy
8:10 am	ABT-963	15 min	15 min	Granneman/Doan/Bell
8:40 am	BSF 201640	30 min	10 min	B. Rendenbach-Mueller
9:20 am	BSF 74398 (Parkinson)	30 min	10 min	S. Dawe
10:00 am	Morning Break			
10:20 am	Dilaudid OROS	45 min	15 min	B. Gold/R. Krautheimer
11:20 am	BSF 190555 (Schizophrenia)	30 min	10 min	B. Rendenbach-Mueller
12:00 pm	Lunch			
1:00 pm	Hydrocodone	10 min	10 min	S. Collins
1:20 pm	Bimocromol (ABT-822)	30 min	10 min	B. Wallin
	Gastro-enterology			
2:00 pm	Ganaton (pro-kinetic)	15 min	5 min	S. Dawe/R. Krautheimer
2:20 pm	TU-199 (proton pump inh.)	30 min	10 min	T. Hirose/ R. Krautheimer
3:00 pm	AU - 224 (colon pro-kinetic)	20 min	5 min	T. Hirose/ R. Krautheimer
3:25 pm	Afternoon Break			
	Phase III Projects			
3:45 pm	ABT-773	30 min	15 min	C. Craft
4:30 pm	D2E7	45 min	30 min	C. Spiegler/E. v. Borcke

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**Portfolio Review Meeting
March 7 – 9, 2001
The Hyatt Deerfield**

Friday, March 9

Phase III Projects (cont'd)

		Presentation	Discussion	
7:30 am	Segard	45 min	15 min	L. Daum/T. King
8:30 am	J695	30 min	10 min	R. Janocha/T. King
9:10 am	Clivarine	30 min	15 min	F. Misselwitz/S. Schaeffer
9:55 am	Morning Break			
10:15 am	Rythmol SR	30 min	15 min	A. Pethö-Schramm/E. Schneider
11:00 am	Levosimendan	30 min	15 min	C MacLeod

Phase IV Projects

11:45 am	Clarithromycin	15 min	5 min	C. Olson
12:05 pm	Omnicef	15 min	5 min	C. Olson
12:25 pm	Lunch			
1:25 pm	Kaletra	15 min	5 min	E. Sun
1:45 pm	Norvir	15 min	5 min	E. Sun
2:05 pm	Meridia (Sibutramine)	15 min	5 min	E. Chong/W. Hargan
2:25 pm	Uprima	15 min	5 min	S. Bukofzer
2:45 pm	Trandolapril (patch, intervention trials)	15 min	5 min	B. Rendbach-Mueller/ U. Legler/N. Bender
3:05 pm	Afternoon Break			
3:25 pm	Fenofibrate	15 min	5 min	D. Yannicelli
3:45 pm	Depakote	15 min	5 min	K. Sommerville
4:05 pm	Gengraf	15 min	5 min	T. Japour
4:25 pm	Conclusion			Jeff Leiden

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Deposition Exhibit 7

P's Exhibit GW

INITIAL PORTFOLIO PRIORITIZATION

C- continue
P- pending
T- terminate

Project	Priority	Next steps	Responsibility	Timing
Anti-infectives ABT-492	C	<ul style="list-style-type: none"> Address safety issues (including QTc) with internal/ expert review Determine how many indications at launch (pay back) 	• J. Leonard	-
HSR-803	T	<ul style="list-style-type: none"> Consider trading with Delcort Halt any new expenditure 	• J. Tyree	-
ABT-773	C	<ul style="list-style-type: none"> Assess side effects issues with expert review (QTc and liver tox.) Ensure all drug interactions are adequately covered Assess relative to Ketek 	• J. Leonard • J. Leonard • E. Low	-
Urology BSF 420627	P	<ul style="list-style-type: none"> Set up task force to address issues and bring back plan to senior management Reasons for failure of the SKB ETa/b antagonist Design short (~4 week) PoP trial for symptom relief Rationale for sustained release formulation Nature of the Schwarz Pharma relationship 	• J. Leonard	• By May
Hypothyroidism T3/T4	P	<ul style="list-style-type: none"> Assess most appropriate ratio Gain FDA feedback on study design Determine ex-US market attractiveness (price) 	• J. Leonard	• By May
Asthma Hokunellin tape	P	<ul style="list-style-type: none"> Conduct market research on acceptance by different patient segments Determine how to position against long acting beta agonists and combination inhalers Evaluate opportunity to gain complete access to the patch technology 	• A. Higgins/ E. Fiorentino • J. Tyree	• May

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Leiden EXHIBIT 7
 FOR ID. 4-26-07 JAX

INITIAL PORTFOLIO PRIORITIZATION (CONTINUED)

C- continue
P- pending
T- terminate

Project	Priority	Next steps	Responsibility	Timing
Oncology ABT-510	C	<ul style="list-style-type: none"> Pursue proof of concept Leverage TAP knowledge of angiogenesis product development (appropriate endpoints) 	Project team	As planned
ABT-751	C	<ul style="list-style-type: none"> Pursue proof of concept Use echocardiogram to monitor potential cardiotoxicity 	Project team	As planned
ABT-518	Hold/T	<ul style="list-style-type: none"> Resolve potent drug manufacturing approach Wait for May results from Pfizer (will save ~\$1mil) and re-evaluate Halt all further expenditure 	CMC group Senior management	May
Rubitecan	P	<ul style="list-style-type: none"> Significant clinical rework required (funded by partner)- further in-depth review required Make a proceed decision when 2Q data available 	J. Leonard	By May
Theragyn	P	<ul style="list-style-type: none"> Negative initial scientific perspective - further in-depth review required, e.g., <ul style="list-style-type: none"> Determine if there is a PoC to support claim Address GMP issues Determine best control to demonstrate efficacy Re-look at partnership contract 	J. Leonard	By May
ABT-827	C	<ul style="list-style-type: none"> Seek alternative funding (e.g., NCI) before starting major trial If move ahead <ul style="list-style-type: none"> Determine how to ensure NDA filing in 2004 Get FDA input since survival not primary endpoint Harmonize US and EU study design and inputs Consider partnership (e.g., BI or established oncology player) 	J. Tyres J. Leonard, P. Nisen J. Tyres	By May ASAP By May

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INITIAL PORTFOLIO PRIORITIZATION (CONTINUED)

C- continue
P- pending
T- terminate

Project	Priority	Next steps	Responsibility	Timing
Cardiology/ Thrombosis Dabigatran (LU 135252)	Hold/T	<ul style="list-style-type: none"> • Continue currently budgeted funding for next 6 months • Do not start any new trials (e.g., hypertension planned for May) • Consider out-license or swap 	<ul style="list-style-type: none"> • Project team • J. Tyree 	<ul style="list-style-type: none"> • Ongoing • ASAP
LU 208075	Hold/T	<ul style="list-style-type: none"> • Continue currently budgeted funding for next six months • Look at Myogen deal • Out-license or swap 	<ul style="list-style-type: none"> • Project team • J. Tyree 	<ul style="list-style-type: none"> • ongoing
Levosimendan	C	<ul style="list-style-type: none"> • Conduct detailed expert panel review for trial design 	<ul style="list-style-type: none"> • J. Leonard 	<ul style="list-style-type: none"> • May
PEG-hirudin	P	<ul style="list-style-type: none"> • Set up expert panel for commercial assessment (is diabetes an option?) 	<ul style="list-style-type: none"> • E. Ogunwo 	<ul style="list-style-type: none"> • By May
Ancrod	T	<ul style="list-style-type: none"> • Identify out-licensing opportunities 	<ul style="list-style-type: none"> • J. Tyree 	<ul style="list-style-type: none"> • TBD
Urokinase	P	<ul style="list-style-type: none"> • Market research required on open cath • Match versus tPA in dose-ranging studies to determine efficacy 	<ul style="list-style-type: none"> • E. Fiorentino 	<ul style="list-style-type: none"> • By May
Pro-urokinase	C	<ul style="list-style-type: none"> • Identify opportunities to speed up program 	<ul style="list-style-type: none"> • Project team 	<ul style="list-style-type: none"> • TBD
Citvarine	C	<ul style="list-style-type: none"> • Assessment by HPD (review previous evaluation and new trial data) • Understand finished product manufacturing cost 	<ul style="list-style-type: none"> • E. Ogunwo • B. Dempsey 	<ul style="list-style-type: none"> • By May
Rythmol SR	C	<ul style="list-style-type: none"> • Continue filing • Verify II package is likely approvable • Assess commercial attractiveness in a generic market 	<ul style="list-style-type: none"> • Project team 	<ul style="list-style-type: none"> • Ongoing

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INITIAL PORTFOLIO PRIORITIZATION (CONTINUED)

C- continue
P- pending
T- terminate

Project	Priority	Next steps	Responsibility	Timing
Neuroscience				
ABT 594	P	<ul style="list-style-type: none"> • Await results from ongoing PII trial – probable T • Project team to develop decision criteria for go/no go 	• Senior management	• June/ July
ABT 963	C	<ul style="list-style-type: none"> • Identify a co-development/co-promotion partner (TAP high on list) • Evaluate benefits of the long half life in pain and cancer (including additional physician market research) • Explore cancer prophylaxis and Alzheimer's indications 	• J. Tyree	• TBD
BSF 201640	P	<ul style="list-style-type: none"> • Complete review of all schizophrenia NCEs with expert panel • Complete staffing of internal project team, but halt further expenditure beyond looking at hepatic tox. and QTc • Understand Novartis contract and level of interest 	• I. Loew	• By May
BSF 190556	P	<ul style="list-style-type: none"> • Complete review as above • Halt further expenditure pending outcome 	• J. Tyree	• Project team
BSF 74398	C (no cost)	<ul style="list-style-type: none"> • Allow DevCo to continue development • Re-look at relationship with DevCo 	• I. Loew	• As above
Diflucan	Hold/T	<ul style="list-style-type: none"> • Return to ALZA or out-license to other interested partner 	• Project team	• By May
Hydrocodone	C	<ul style="list-style-type: none"> • Assess regulatory pathway • Understand DEA impact on manufacturing 	• J. Tyree	• TBD
Bimocromol (ABT 822)	P	<ul style="list-style-type: none"> • Await data from ongoing trial in April before deciding whether to continue - probable T • Halt further expenditure pending outcome 	• Project team	• By May
			• Senior management	• April

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INITIAL PORTFOLIO PRIORITIZATION (CONTINUED)

C- continue
P- pending
T- terminate

Project	Priority	Next steps	Responsibility	Timing
Gastro-enterology Ganalon	P	<ul style="list-style-type: none"> • Conduct U.S. commercial assessment with TAP • Assess how to position in Europe versus generics and implications for comparative bid • Develop model to assess spend at different termination points 	<ul style="list-style-type: none"> • E. Fiorentino • Bob Funck 	<ul style="list-style-type: none"> • By June • By May
TU-199	T	<ul style="list-style-type: none"> • Terminate outside Japan 	• Project team	• Immediate
AU-224	C	<ul style="list-style-type: none"> • Develop and pursue a small PoC trial in humans ASAP (consider niche indication first and leverage Mariene's expertise) • Conduct market research on IBS versus constipation (including pricing) 	<ul style="list-style-type: none"> • Project team • E. Fiorentino 	• ASAP
Immunology D2E7	C	<ul style="list-style-type: none"> • Conduct intensive product review <ul style="list-style-type: none"> - 2 day meeting with J. Leonard's group (already in process) - 1/2 day session with senior management group • Important actions include <ul style="list-style-type: none"> - Approach FDA for fast track and compassionate use - Develop strategy for DMARD claim in first submission - Assess need for Entrel assay to detect HAHAs - Assess delivery device options - Evaluate additional indications (e.g., Psoriasis, Crohns, heart failure) and pediatric program - Profile Celltech product - Assess impact of additional IV program on reimbursement • Develop list of potential marketing partners for quide 	<ul style="list-style-type: none"> • J. Leonard • Various • J. Tyree 	<ul style="list-style-type: none"> • By May • By May

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INITIAL PORTFOLIO PRIORITIZATION (CONTINUED)

G- continue
P- pending
T- terminate

Project	Priority	Next steps	Responsibility	Timing
Immunology (continued) Segard	Hold	<ul style="list-style-type: none"> • Continue filing in EU and Canada • Put on hold in US -- consider creating a small team in the US to analyse data, propose smaller PII study • Research pricing, marketing and Phase IV plans in Europe • Look at TNF-alpha levels retrospectively to see stratification with IL-6 • Assess manufacturing strategy • Identify potential out-licensing opportunities (Genentech) 	<ul style="list-style-type: none"> • Project team • J. Leonard 	• Ongoing
J695	P	<ul style="list-style-type: none"> • Decide on most attractive indications from Abbott and partner perspective • Discuss with partner ways to share the various indications and potential for TNF-alpha combinations • Add commercial person to the project team by this week 	<ul style="list-style-type: none"> • J. Tyree • E. Fiorentino • J. Tyree • Ongoing 	• ASAP

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INITIAL PORTFOLIO PRIORITIZATION (CONTINUED)

G- continue
P- pending
T- terminate

Project	Priority	Next steps	Responsibility	Timing
PIV programs				
Clarithromycin	C	• None identified	-	-
Omnicef	C	• None identified	-	-
Kaletra	C	• None identified	-	-
Norvir	C	• None identified	-	-
Meridia	Hold	<ul style="list-style-type: none"> • Conduct commercial assessment for CNS and depression (P&L) • Assess combination therapy with fibrates • Assess outcomes trial design to meet preferred commercial profile; determine payback 	<ul style="list-style-type: none"> • B. Dempsey, J. Amott, E. Fiorentino • Project team 	<ul style="list-style-type: none"> • ASAP
Uprima	C	• Ensure no redundant trials with TAP in Europe	• Project team	• Ongoing
Trandolapril patch	T	• Halt all activities	• Project team	• Immediate
Trandolapril "invest" clinical program	P	• Review trial in more detail (reduce complexity and risk)	• E. Fiorentino	• By May
Other trandolapril trials	C	• Continue "Create", "Peace" and "Benedict" trial programs	• Project team	• Ongoing
Fenofibrate	C	• Develop co-formulation ideas with Meridia and statins (including assessment of sales and costs)	• Project team	-
Depehote	C	• None identified	-	-
Gengraf	C	• None identified	-	-

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Deposition Exhibit 10

P's Exhibit SO

**Pharmaceuticals
Strategy Update**

September 2000

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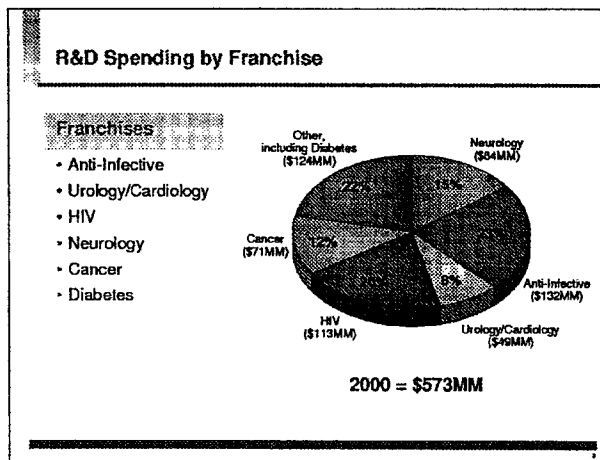
Leiden EXHIBIT *10*
FOR I.D. *4-26-07* *jar*

For the past 18 months, PPD has been implementing a four-point strategy designed to achieve and sustain double-digit sales growth

- Create focused commercial and development Franchises that provide a focused platform for future new products, to improve critical mass in R&D and Marketing
- Re-engineer R&D operations and grow R&D dollars to increase the output of internally-developed new products and line extensions
- Fill the short-term sales gap by accessing new products through an aggressive in-licensing program: focusing on products which broaden existing Franchises
- To sustain long-term growth, pursue strategically attractive acquisitions, with particular focus on biotech and specialty manufacturers

This strategy was first presented to the Board at last year's June meeting in London

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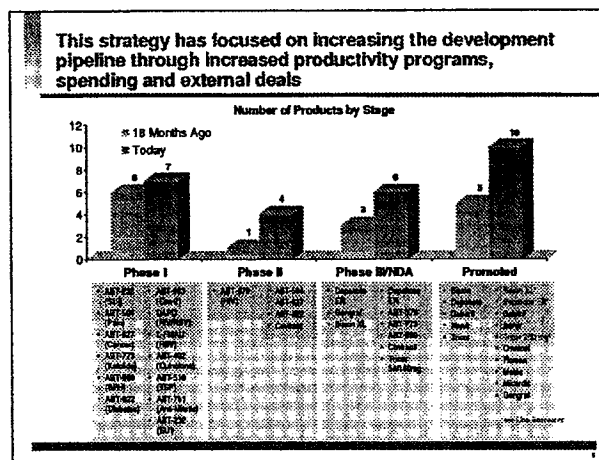


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Abbott has in-licensed 10 new pharma compounds over the last 18 months

Company	Product(s)	Deal Terms
• BI	• Flomax, Micardis, Mobic	• Abbott distributes products in return for 5% distribution fee, fee per detail and tiered sales commission
• Triangle	• Coactinon, Coviracil, L-FMAU, DAPD	• Abbott co-promotes with Triangle receiving 55% of domestic profit and 60% of international profit
• Warner-Lambert	• Omnicel	• Abbott bought rights to sell Omnicel domestically
• Sangstat	• Gengral	• Co-promotion with Abbott; Sangstat receives 20% of net distribution margin; Abbott has stock purchase and loan agreements
• TEVA	• Generic Terazosin	• Abbott sells finished product to TEVA and shares in TEVA's sales to 3rd parties

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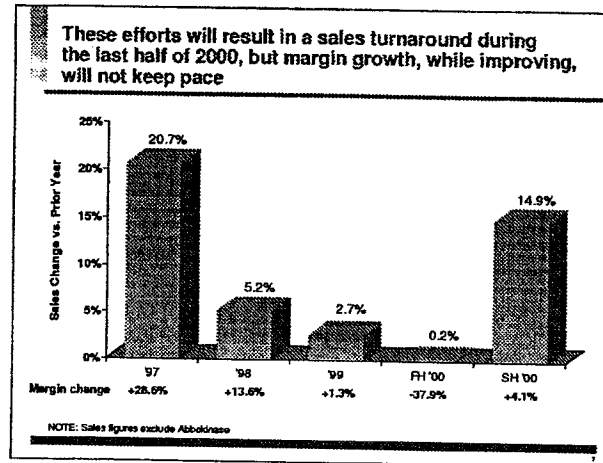


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KALETRA (ABT-378), Abbott's new Protease inhibitor for the treatment of AIDS, is the most exciting of these new compounds

- The goal of the R&D team was to create a "best in class" protease inhibitor. This was achieved with superior efficacy results in place
- Development was accelerated resulting in 46 months from first-in-man to approval, over a year faster than the norm
- Expected approval in the U.S. in September 2000
- Peak year global sales could reach \$600MM

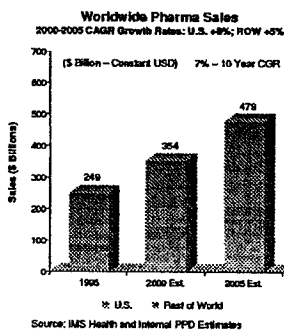
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It makes sense to grow the Abbott pharma business from commercial and scientific perspectives

- The pharmaceutical industry is one of the world's largest and most profitable industries. Growth is expected to continue
 - Global economic growth
 - Aging population
 - Acceptance of "lifestyle" drugs
- Recent advances in genomics and molecular genetics will greatly facilitate new drug discovery



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There will be both external and internal challenges to growing the Abbott pharma business

• External challenges

- Downward price pressure will continue, particularly in the U.S.
- Increasingly strict regulatory environment (product recalls, safety standards, clinical requirements) will lead to greater R&D costs as well as longer development timelines
- Increasingly rigorous regulatory and QA environment will add significant costs

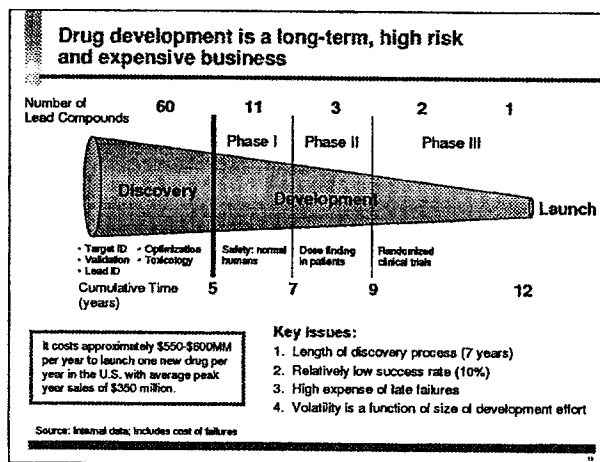
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There will be both external and internal challenges to growing the Abbott pharma business

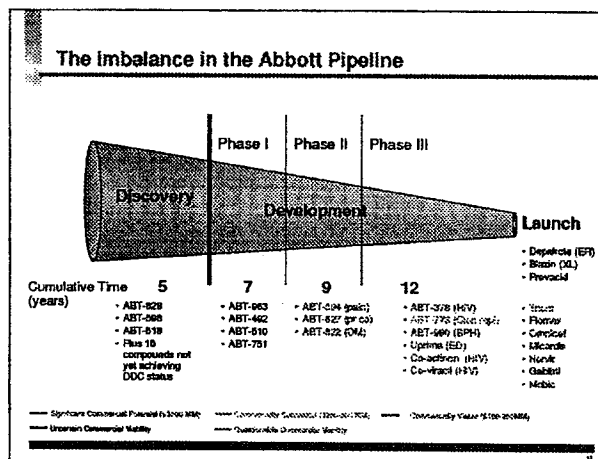
• Internal challenges

- The imbalance of our pharma pipeline
 - Many early stage compounds;
not enough late-stage drugs
- Affordability
 - We cannot currently afford to develop enough early-stage compounds to sustain long-term growth
- Long-term loss of sales/commissions and margin from Prevacid (2004), Biacin (2005) and Depakote (2008)

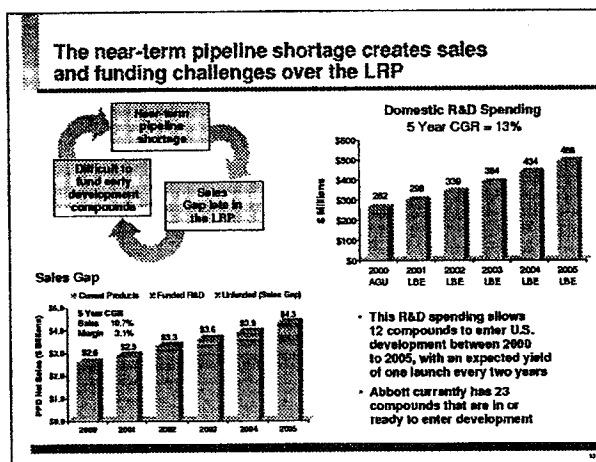
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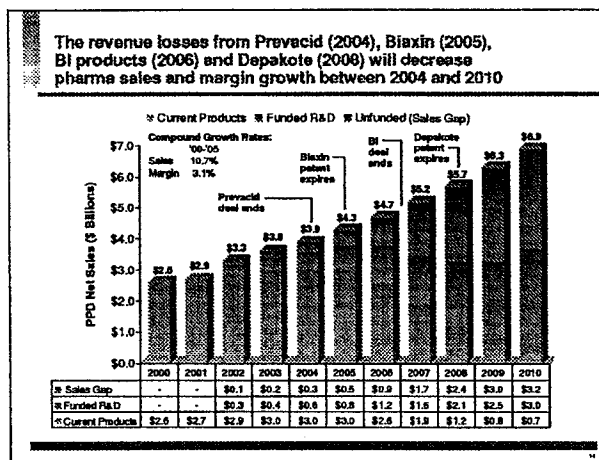
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Abbott's Pharma business faces both near- and long-term challenges

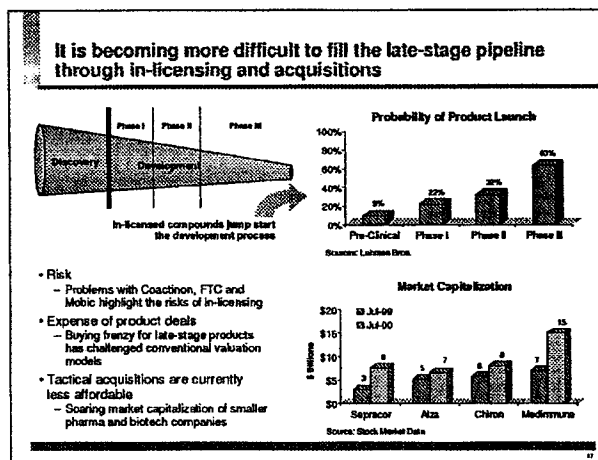
- Near-term challenges (2001-2005)
 - Relative lack of late-stage compounds creates a sales gap by the end of the LRP
 - Emphasis on in-licensed compounds dampens margin growth to create a significant margin gap over the LRP
- Long-term challenges
 - Margin loss from three major products (Blaxin, Depakote and Prevacid) between 2005 and 2008
 - There are not enough currently funded early-stage compounds in the development pipeline to support double-digit sales growth of the pharma business
 - It is difficult to fund the development of the early compounds that we have without further actions

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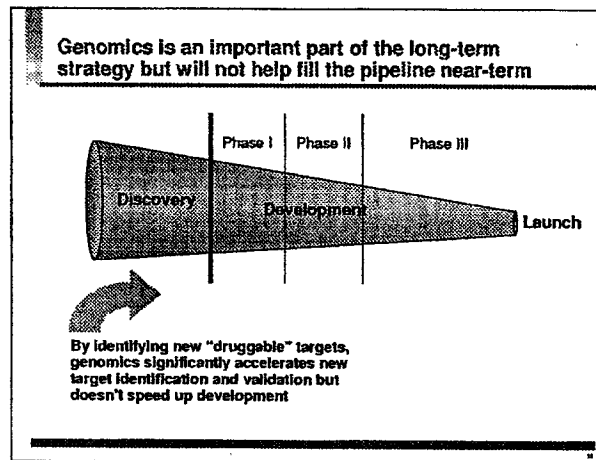
Abbott's strategies for addressing the challenges of the Pharma business remain the same

- Loading the pipeline with more late-stage compounds
 - In-licensing
 - Acquisition of small- and mid-cap biotech/pharma companies
 - Co-marketing deals with other pharma companies
- Increasing R&D spending to develop more early-stage compounds
 - Creative deals for outside funding
 - John Hancock (\$200MM over four years for R&D in exchange for a royalty on developed drugs)
 - Acquisition of companies with R&D spending
 - Alliances with companies that are willing to co-fund development
 - Abbott is currently pursuing such a deal with Millennium in the areas of diabetes and obesity
 - Utilization of genomics and other technology advances to increase the efficiency of the R&D process

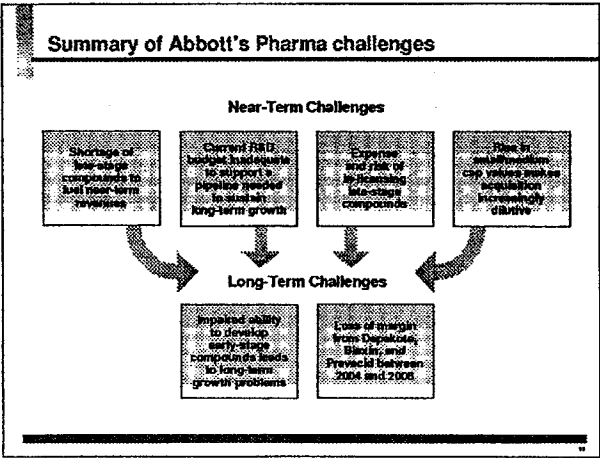
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Conclusions

- Our current strategies of in-licensing, internal R&D, and small deals for late stage compounds should allow us to fill the sales and margin gap in the LRP
- The growth associated with these strategies has to be accelerated and additional initiatives (e.g., more focused R&D; larger, opportunistic acquisitions) have to be implemented to offset sales and margin losses from Prevacid, Biaxin and Depakote between 2004 and 2008

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Deposition Exhibit 11

P's Exhibit SP

Pharmaceuticals Strategy Update

September 2000

For D. 4 26-07-1 *ggh*
EXHIBIT *11*

CONFIDENTIAL
ABBT0577835

For the past 18 months, PPD has been implementing a four-point strategy designed to achieve and sustain double-digit sales growth

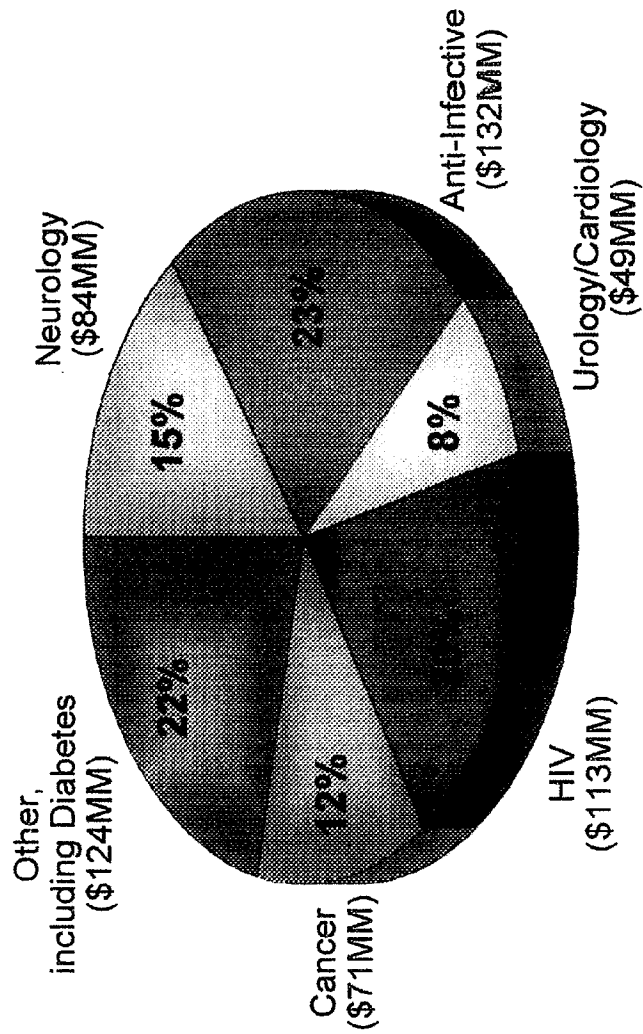
- Create focused commercial and development Franchises that provide a focused platform for future new products, to improve critical mass in R&D and Marketing
- Re-engineer R&D operations and grow R&D dollars to increase the output of internally-developed new products and line extensions
- Fill the short-term sales gap by accessing new products through an aggressive in-licensing program: focusing on products which broaden existing Franchises
- To sustain long-term growth, pursue strategically attractive acquisitions, with particular focus on biotech and specialty manufacturers

***This strategy was first presented to the Board
at last year's June meeting in London***

R&D Spending by Franchise

Franchises

- Anti-Infective
- Urology/Cardiology
- HIV
- Neurology
- Cancer
- Diabetes



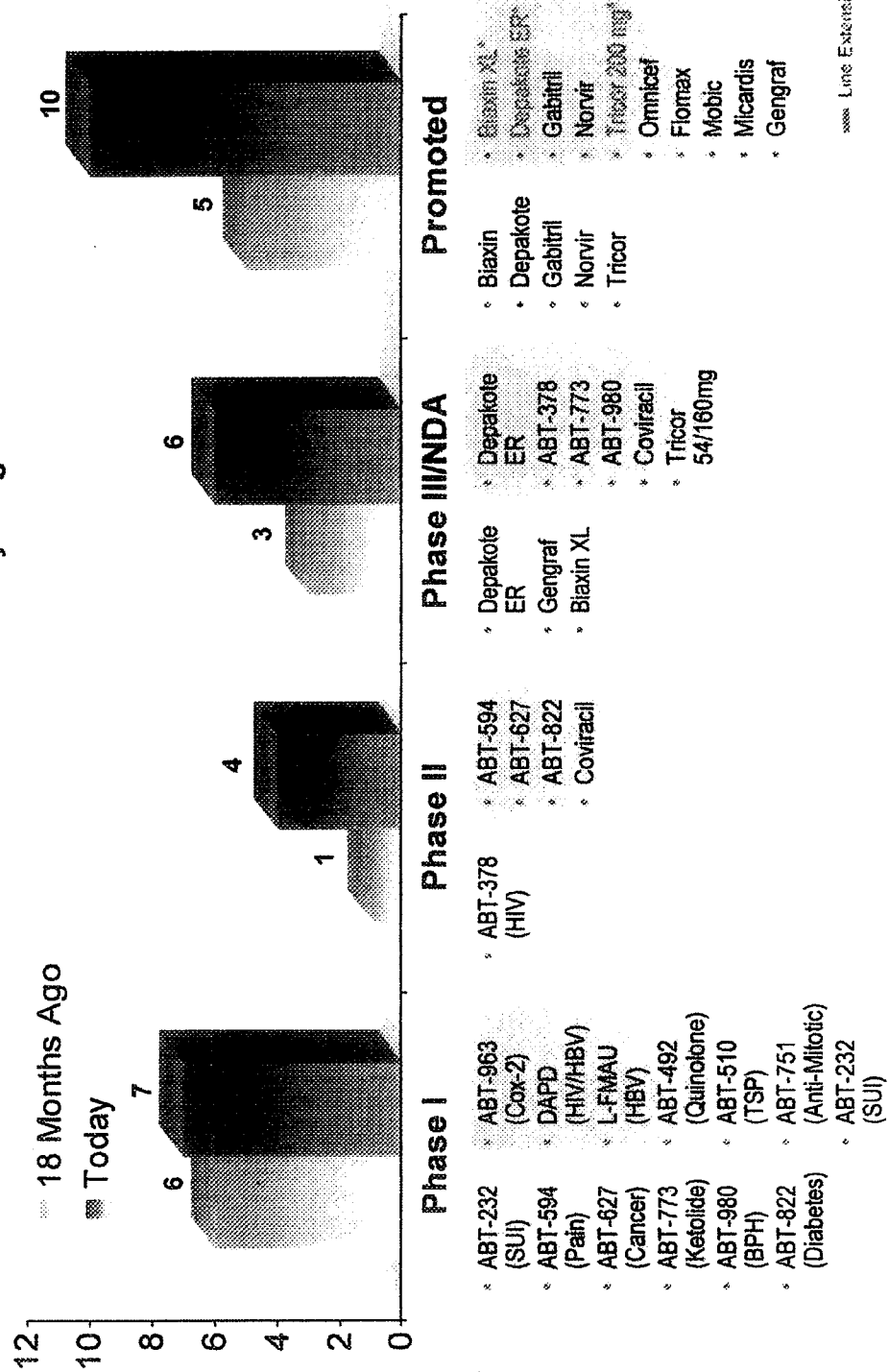
2000 = \$573MM

Abbott has in-licensed 10 new pharma compounds over the last 18 months

Company	Product(s)	Deal Terms
* BI	* Flomax, Micardis, Mobic	* Abbott distributes products in return for 5% distribution fee, fee per detail and tiered sales commission
* Triangle	* Coactinon, Coviracil, L-FMAU, DAPD	* Abbott co-promotes with Triangle receiving 55% of domestic profit and 60% of international profit
* Warner-Lambert	* Omnicef	* Abbott bought rights to sell Omnicef domestically
* Sangstat	* Gengraf	* Co-promotion with Abbott; Sangstat receives 20% of net distribution margin; Abbott has stock purchase and loan agreements
* TEVA	* Generic Terazosin	* Abbott sells finished product to TEVA and shares in TEVA's sales to 3rd parties

This strategy has focused on increasing the development pipeline through increased productivity programs, spending and external deals

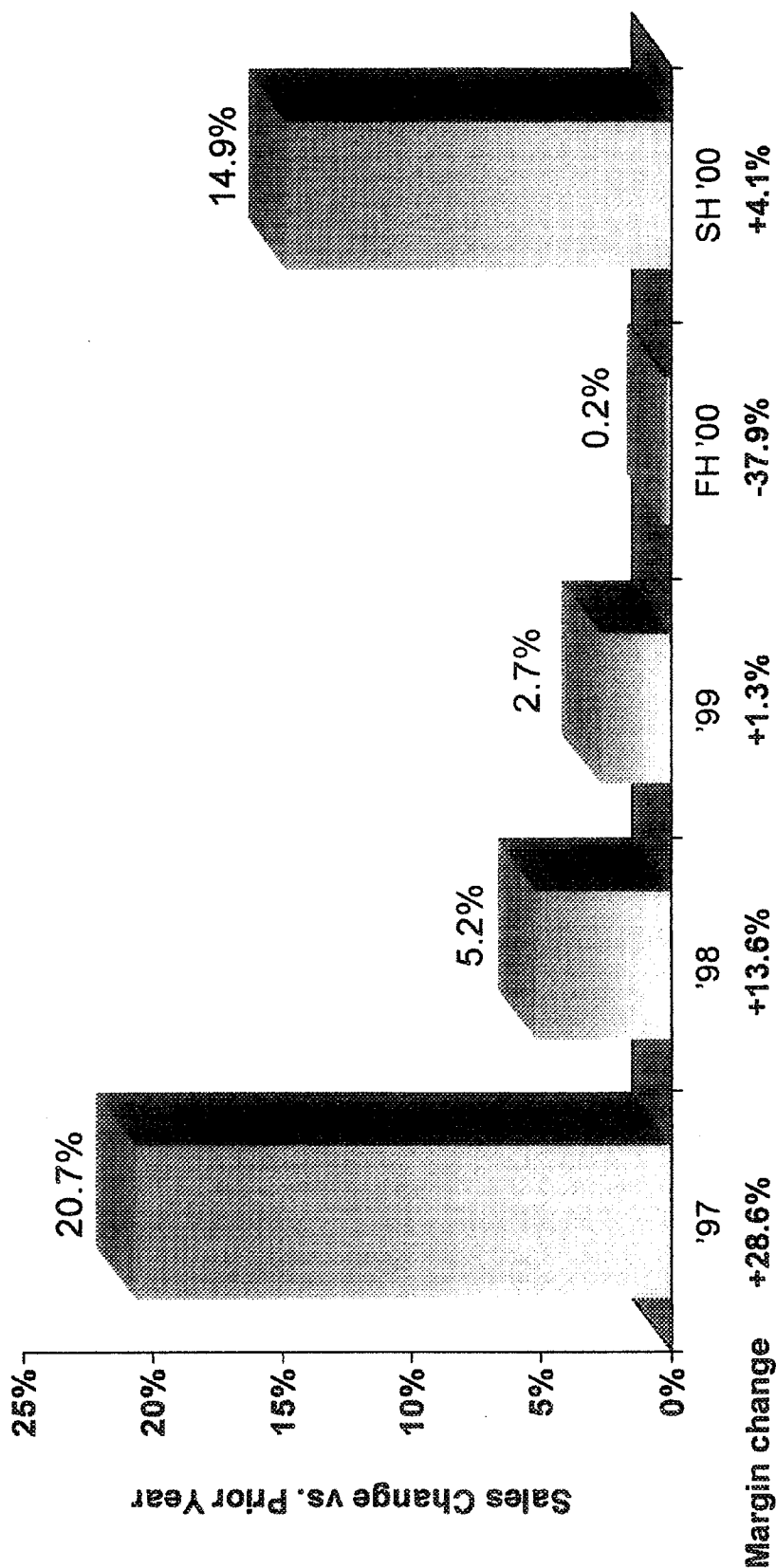
Number of Products by Stage



KALETRA (ABT-378), Abbott's new Protease Inhibitor for the treatment of AIDS, is the most exciting of these new compounds

- The goal of the R&D team was to create a "best in class" protease inhibitor. This was achieved with superior efficacy results in place
- Development was accelerated resulting in 46 months from first-in-man to approval, over a year faster than the norm
- Expected approval in the U.S. in September 2000
- Peak year global sales could reach \$600MM

These efforts will result in a sales turnaround during the last half of 2000, but margin growth, while improving, will not keep pace

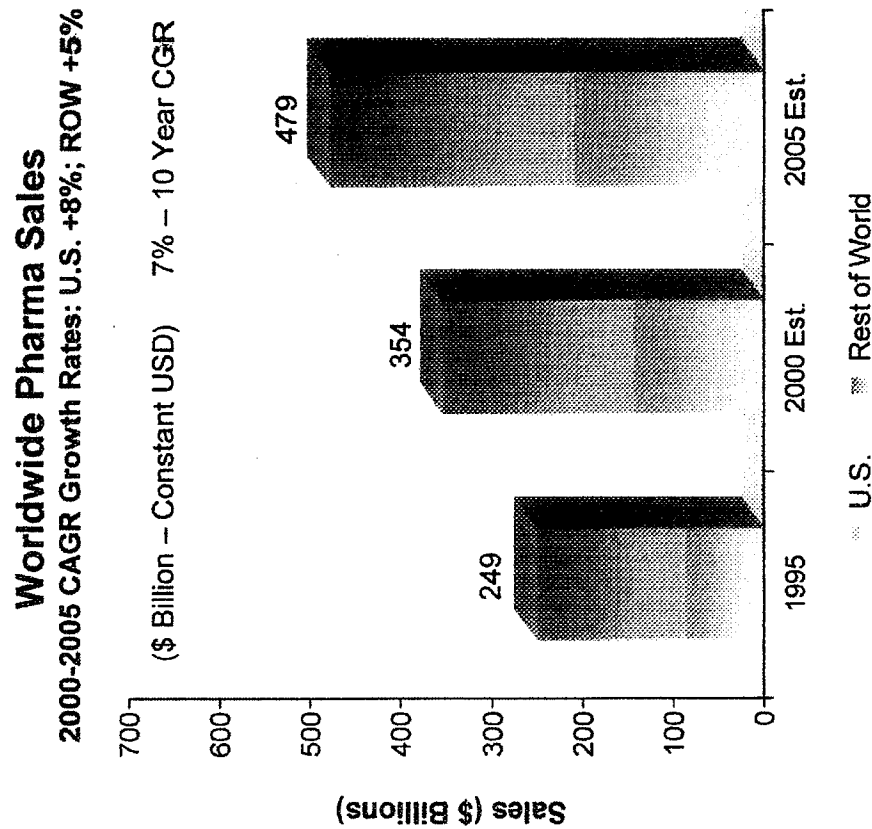


NOTE: Sales figures exclude Abbokinase

It makes sense to grow the Abbott pharma business from commercial and scientific perspectives

- The pharmaceutical industry is one of the world's largest and most profitable industries. Growth is expected to continue
 - Global economic growth
 - Aging population
 - Acceptance of "lifestyle" drugs

- Recent advances in genomics and molecular genetics will greatly facilitate new drug discovery



Source: IMS Health and Internal PPD Estimates

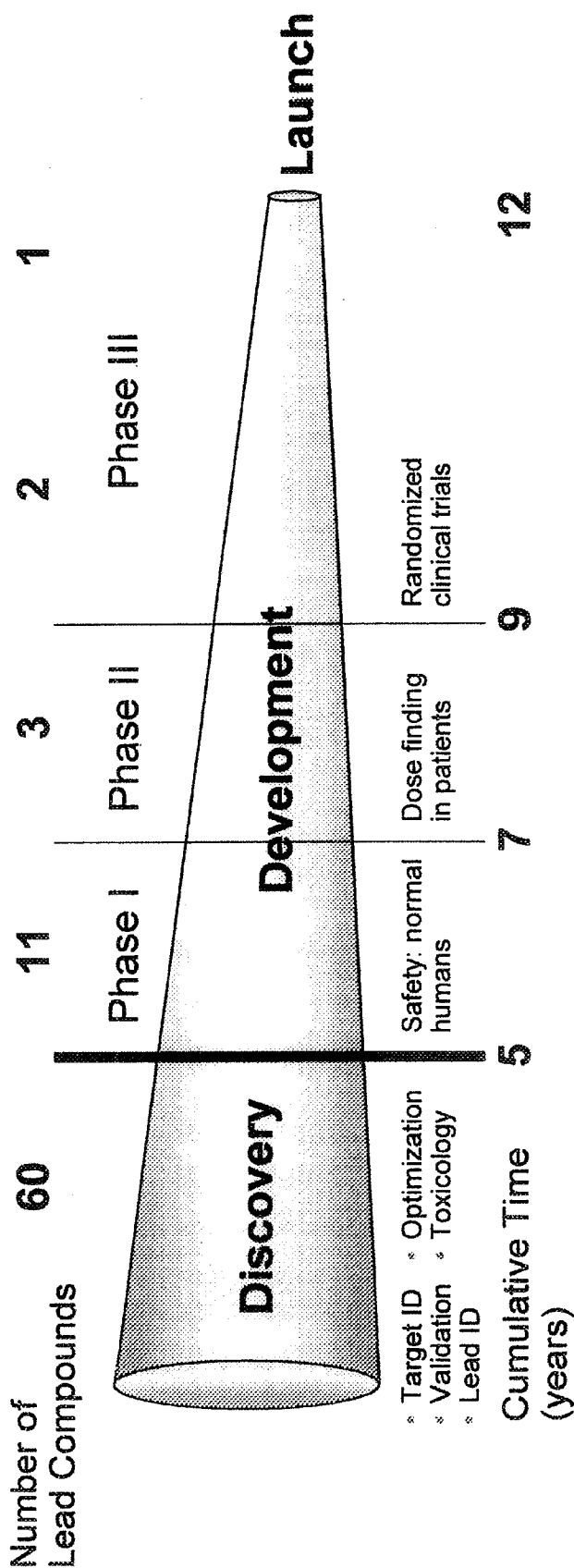
There will be both external and internal challenges to growing the Abbott pharma business

- External challenges
 - Downward price pressure will continue, particularly in the U.S.
 - Increasingly strict regulatory environment (product recalls, safety standards, clinical requirements) will lead to greater R&D costs as well as longer development timelines
 - Increasingly rigorous regulatory and QA environment will add significant costs

There will be both external and internal challenges to growing the Abbott pharma business

- **Internal challenges**
 - The imbalance of our pharma pipeline
 - Many early stage compounds; not enough late-stage drugs
 - Affordability
 - We cannot currently afford to develop enough early-stage compounds to sustain long-term growth
 - Long-term loss of sales/commissions and margin from Prevacid (2004), Biaxin (2005) and Depakote (2008)

Drug development is a long-term, high risk and expensive business



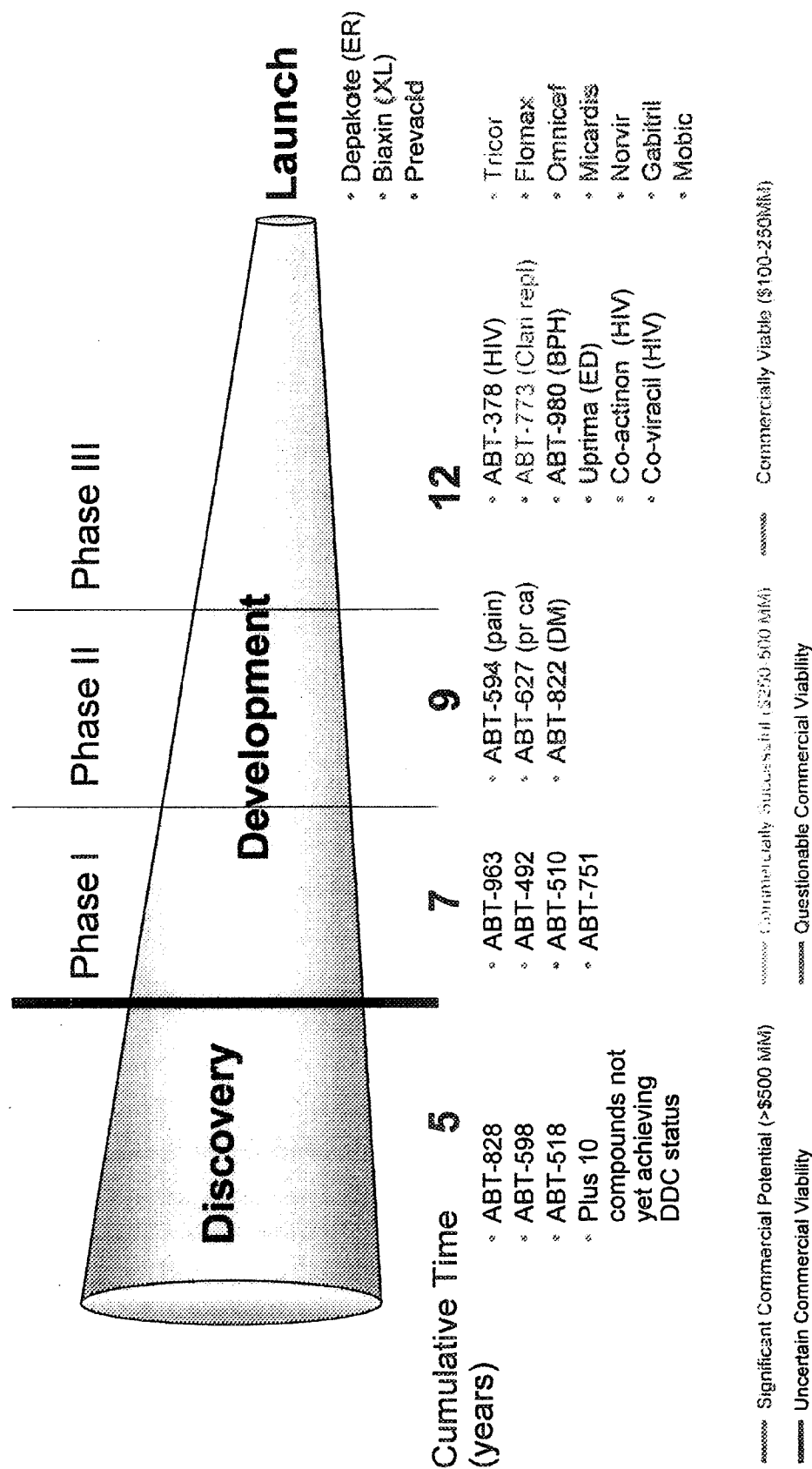
Key Issues:

1. Length of discovery process (7 years)
2. Relatively low success rate (10%)
3. High expense of late failures
4. Volatility is a function of size of development effort

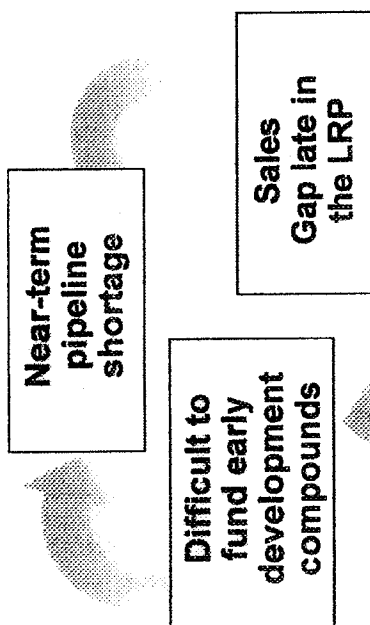
It costs approximately \$550-\$600MM per year to launch one new drug per year in the U.S. with average peak year sales of \$350 million.

Source: Internal data; includes cost of failures

The imbalance in the Abbott Pipeline

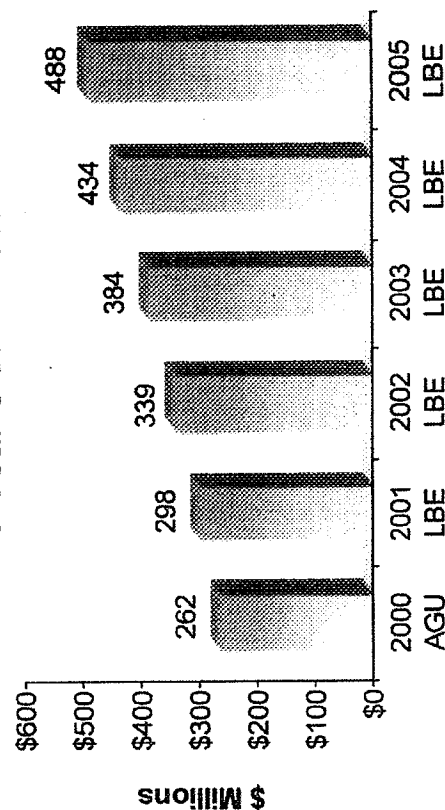


The near-term pipeline shortage creates sales and funding challenges over the LRP

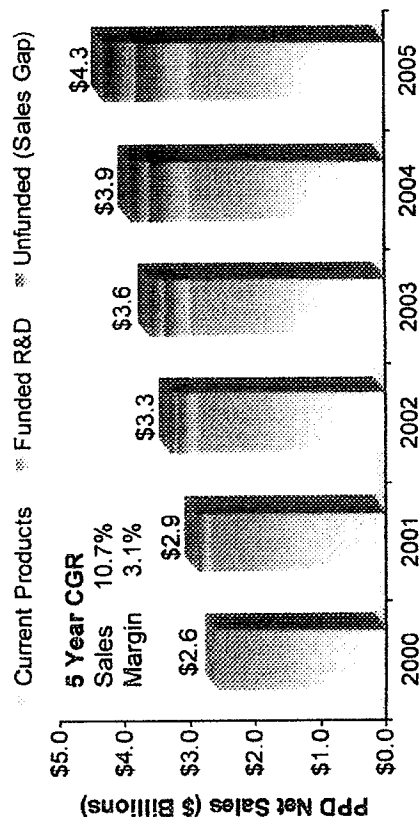


Domestic R&D Spending

5 Year CGR = 13%

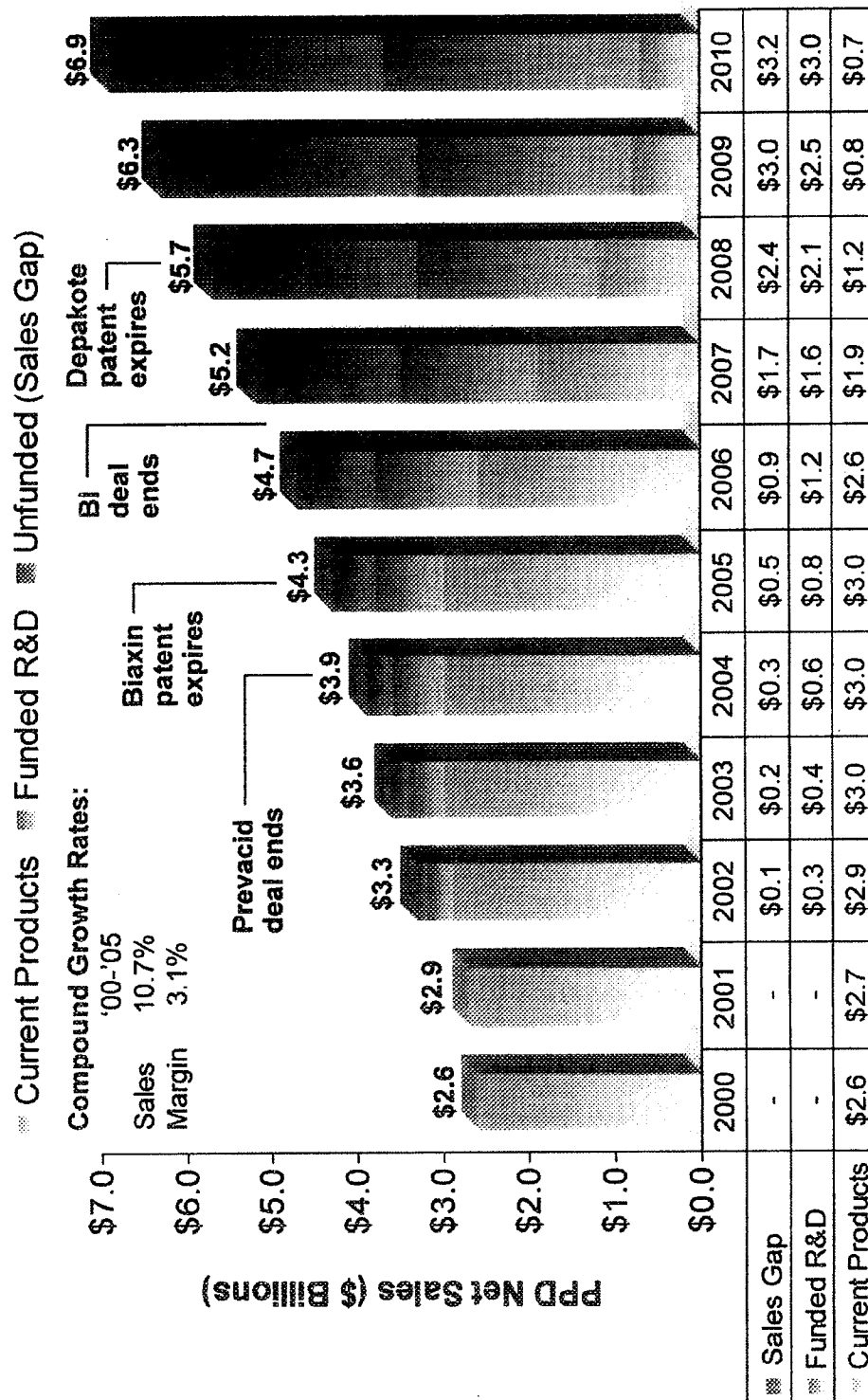


Sales Gap



- * This R&D spending allows 12 compounds to enter U.S. development between 2000 to 2005, with an expected yield of one launch every two years
- * Abbott currently has 23 compounds that are in or ready to enter development

The revenue losses from Prevacid (2004), Biaxin (2005), BI products (2006) and Depakote (2008) will decrease pharma sales and margin growth between 2004 and 2010



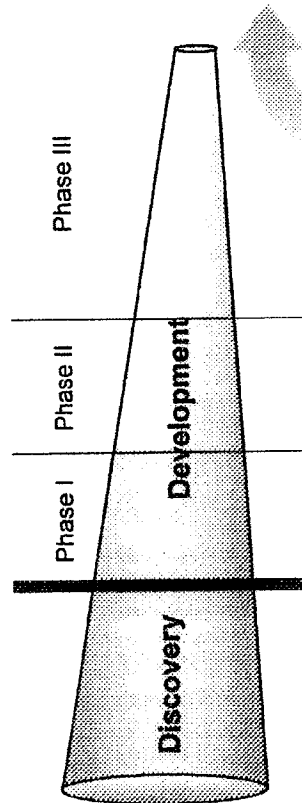
Abbott's Pharma business faces both near- and long-term challenges

- Near-term challenges (2001-2005)
 - Relative lack of late-stage compounds creates a sales gap by the end of the LRP
 - Emphasis on in-licensed compounds dampens margin growth to create a significant margin gap over the LRP
- Long-term challenges
 - Margin loss from three major products (Biaxin, Depakote and Prevacid) between 2005 and 2008
 - There are not enough currently funded early-stage compounds in the development pipeline to support double-digit sales growth of the pharma business
 - It is difficult to fund the development of the early compounds that we have without further actions

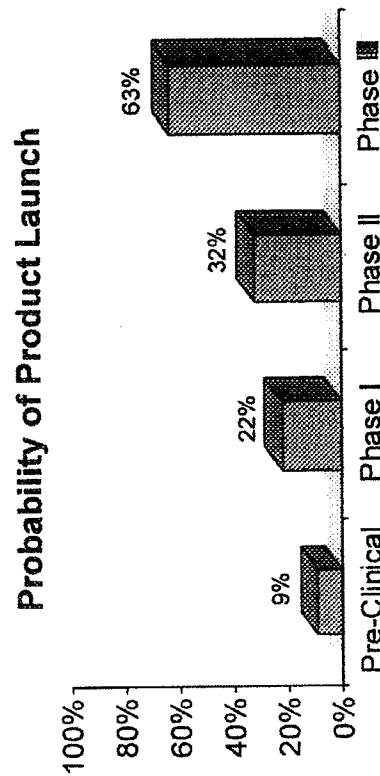
Abbott's strategies for addressing the challenges of the Pharma business remain the same

- * Loading the pipeline with more late-stage compounds
 - In-licensing
 - Acquisition of small- and mid-cap biotech/pharma companies
 - Co-marketing deals with other pharma companies
- * Increasing R&D spending to develop more early-stage compounds
 - Creative deals for outside funding
 - * John Hancock (\$200MM over four years for R&D in exchange for a royalty on developed drugs)
 - Acquisition of companies with R&D spending
 - Alliances with companies that are willing to co-fund development
 - * Abbott is currently pursuing such a deal with Millennium in the areas of diabetes and obesity
 - Utilization of genomics and other technology advances to increase the efficiency of the R&D process

It is becoming more difficult to fill the late-stage pipeline through in-licensing and acquisitions



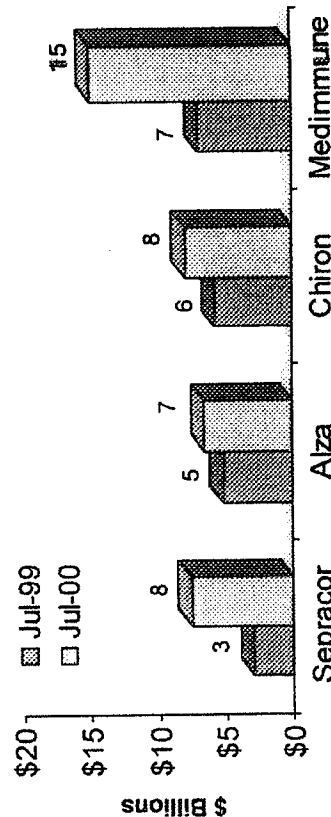
In-licensed compounds jump start the development process



Sources: Lehman Bros.

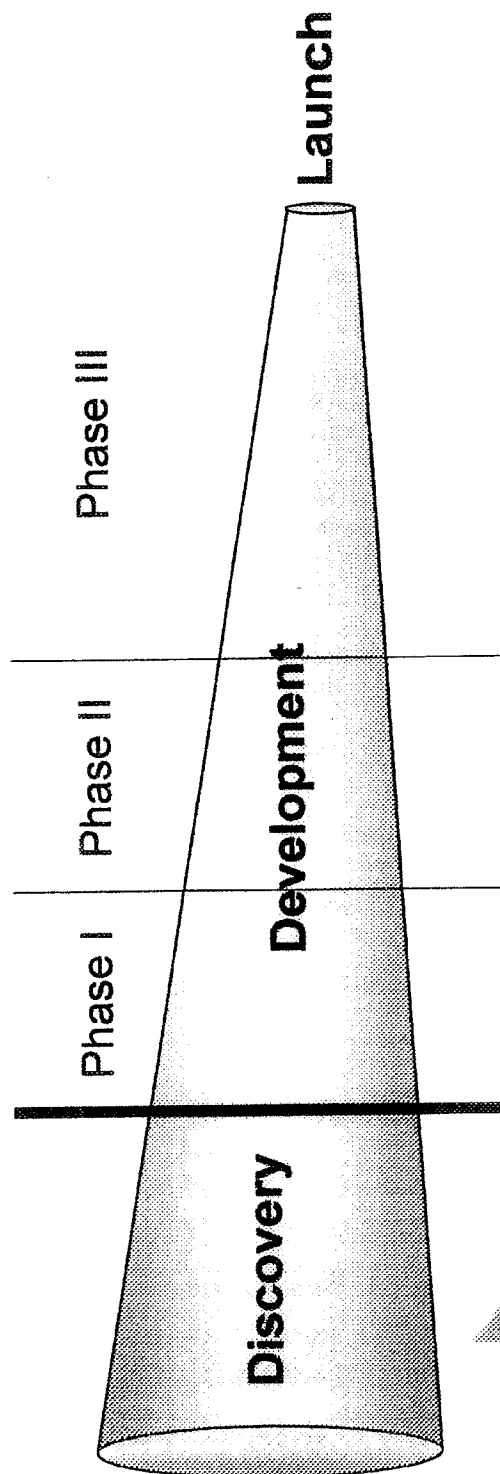
- * Risk
 - Problems with Coaction, FTC and Mobic highlight the risks of in-licensing
- * Expense of product deals
 - Buying frenzy for late-stage products has challenged conventional valuation models
- * Tactical acquisitions are currently less affordable
 - Soaring market capitalization of smaller pharma and biotech companies

Market Capitalization



Source: Stock Market Data

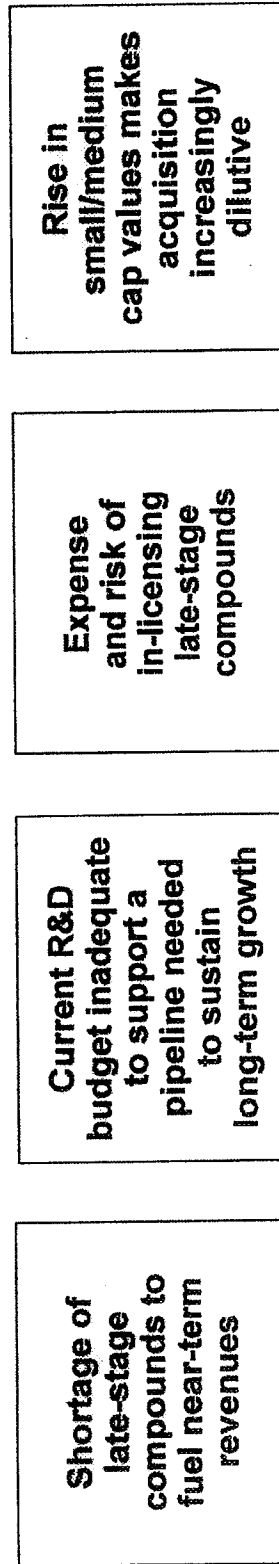
Genomics is an important part of the long-term strategy but will not help fill the pipeline near-term



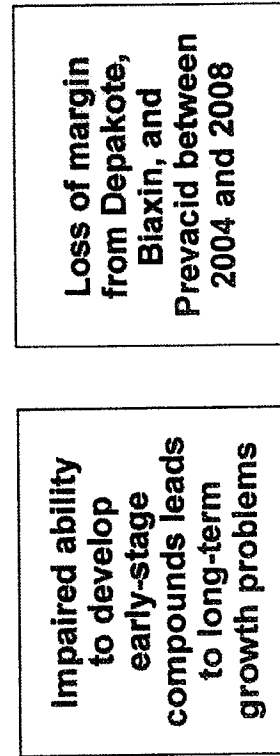
By identifying new “druggable” targets, genomics significantly accelerates new target identification and validation but doesn’t speed up development

Summary of Abbott's Pharma challenges

Near-Term Challenges



Long-Term Challenges



Conclusions

- Our current strategies of in-licensing, internal R&D, and small deals for late stage compounds should allow us to fill the sales and margin gap in the LRP
- The growth associated with these strategies has to be accelerated and additional initiatives (e.g., more focused R&D; larger, opportunistic acquisitions) have to be implemented to offset sales and margin losses from Prevacid, Biaxin and Depakote between 2004 and 2008

Deposition Exhibit 14

P's Exhibit DE



Mike
Williams /LAKE/PPRD/ABBO
TT

10/12/2000 03:01 PM

To Jennifer Smoter/LAKE/PPD/ABBOTT@ABBOTT
cc Christopher J Silber/LAKE/PPRD/ABBOTT@ABBOTT

bcc

Subject Re: NNR documents

Jennifer: I think Mike Decker has addressed some of the document issues. Another real issue we must address given some of the internal discussions around the clinical trials on ABT-594 is whether we want to make any statements in the next few weeks until a decision is made by Jeff Leiden as to whether we continue the trials.

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Leiden EXHIBIT 14
FOR ID. 4-26-07 JMK

Deposition Exhibit 20

P's Exhibit DU

December 2000
ABT-594 Project Status Report

Key Issues/Decisions/Events

Area	Issue/Decision/Event	Progress
Venture	Closing of enrollment on M99-114 as of January 5, 2001	<ul style="list-style-type: none"> Enrollment will be closed on this revised date. Timeline Impact will be reviewed in January
PARO	During investigative work on implementation of the Mitsunobu chemistry route, a modification was made to the analytical method, which improved separation of some peaks. Using this method, an additional unknown impurity (designated as F') was detected in the lot of bulk drug used in M99-114 clinical capsules. Given the low exposure of M99-114 patients to F' and a lack of change in acute toxicity when this impurity was present in the drug substance, Toxicology does not view the presence of this impurity as a significant risk to these patients. However, further toxicology and pk testing of this impurity is necessary. Planned studies include Ames assay, in vitro micronucleus assay and bioavailability study	<ul style="list-style-type: none"> This issue has been reviewed with PARO, SPD, Toxicology, Regulatory and Ventura Management. To date, the F' impurity has been detected at a level of 0.2% in the drug substance. Tentative identification including molecular structure has been made. Due to significant chemistry challenges, the delivery of impurity F' to PARO from SPD is delayed. New target date to be determined pending favorable results from current synthesis efforts. PARO Analytical will be testing the F' material to confirm identity and match to Plans are to manufacture a single production-scale lot planned January 2001 When testing is successfully completed, F' material will be tested for genotoxicity by Toxicology and for bioavailability by Exploratory Kinetics
SPD	Team has recommended implementation of the Mitsunobu chemistry change in step 4 of the synthetic process to eliminate the risk of mesylate impurity, which is potentially mutagenic.	PARO Analytical is completing analysis of lab-scale batch and intermediates to assure there are no new impurities to be found.
NPD	Portfolio analysis process is underway for ABT 594 and will impact budget allocation for 2001. A new forecast using updated NPD forecast model with clearly defined product profile and high and low case estimates is being developed and will be reviewed by core team prior to final conduct of portfolio prioritization.	Plans are to manufacture a single production-scale lot in early-2001 with available raw materials, and to wait on the second and third NDA lots until after the Go / No Go decision. ABT 594 portfolio team reviewed the forecasts and profile on 12/19/00. Final adjustments are in process, and will be completed no later than 1/15/01 (just prior to prioritization meeting).
Toxicology	6-month rat study finding may suggest future possible occurrence of hepatocellular neoplasms in long-term toxicology studies.	No adenomas have been found in the study. The in-life phase of the 2-year carcinogenicity study is complete and preliminary data on tumor findings should be available 1Q2001.

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Laden EXHIBIT *20*
FOR ID. 4.26.07.1 *gmr*

December 2000
ABT-594 Project Status Report

\$000's Activity	Project Cost Summary - November					Cumulative to NDA
	Cumulative through 1999	YTD Actual	Projected Year-end	Current Funded Year-end	Variance	
Clinical Program	22.9	7.5	7.5	7.9	.4	157.1
CMC (PARC & SPD)	13.0	2.9	2.9	2.6	-.3	27.6
Drug Safety	8.7	3.4	3.4	2.4	-1.0	18.3
Other Support Costs	0.7	.5	.5	1.5	1.0	12.2
Total	50.5	14.3	14.3	14.4	.1	215.2

File NDA = 9/2003

Protocol # - Study Name	Clinical Study Progress			Total R/OSS \$000	Total Target Patients	Current Enrollment
	Start (1 st Patient Dosed)	End (Last CRF in House)				
M99-114 - A Randomized, Double-Blind, Placebo-Controlled Comparison of the Safety and Efficacy of ABT-594 to Placebo in Subjects with Painful Diabetic Polyneuropathy	04/00	04/01		3,000	320	267 (As of 12/31)

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December 2000 ABT-594 Project Status Report

Business Rationale

Date: November 2000
Franchise: Neuroscience
Venture: Analgesia

ABT #: ABT-594
Trade & Generic Name: TBD, ebanidine fosylate
Mechanism of Action: Neuronal Nicotinic Receptor (NMR) Agonist

Indications: Neuropathic Pain
Chronic Pain (publication only)

Product Profile

Attribute	Date Defined	Probability	Confirm Status	Share Impact
Not scheduled	12/1996	High	1004	High
Chronic nociceptive pain efficacy	10/1999	Medium	2001	High
Neuropathic pain claim	6/1996	Medium	2001	High
General pain claim	12/1996	N/A	N/A	High
Moderate to moderately severe pain	9/1998	Medium	1003	High
No tolerance/dependence or withdrawal	9/1998	High	2001	High
Very few abnormal LFTs	6/1999	Medium	2001	High
Low nausea/vomiting at effective dose	9/1998	Medium	2001/1003	High
Other safety OK	9/1998	High	2001/1003	High
No differential efficacy (nicotine users vs. non users)	9/1998	Medium	2001/1003	Medium
No differential side effect profile (nicotine users vs. non users)	9/1998	N/A	N/A	Medium
No reinitiation of cravings in ex-nicotine users	6/1999	Low	4001	Medium
Onset of action comparable to other therapies for chronic nociceptive pain	6/1999	N/A	N/A	Medium
Onset of action comparable to other therapies for neuropathic pain	6/1999	High	2001	High
BID dosing	12/1996	High	1003	Medium
No major drug interactions	9/1999	Medium	1000	High
Titration of 2.5 days duration is required to minimize nausea and vomiting at effective dose.				

* Probability Key:

High = 70-100%
Medium = 30-69%
Low = 0-29%

Market Forecast

Patent Status:	PPCC/DDC 12/1996*	Plan as of 6/1998*	Current Revised 1/2001**
NDA Filing:	10/2010 (est.)	10/2016 (est.)	10/2016 (est.)
Ex-U.S. Filings:	12/1998 (acute)	12/2001	9/2003
Projected U.S. Launch:	6/2001 (chronic)	12/2001 - Eur	9/2003
Projected ex-U.S. Launches:	Same as above - Eur	12/2003 - Jpn	9/2004
	N/A - Jpn	6/2003	
	12/2001 (acute)		
	12/2002 (chronic)		
	Same as above - Eur	12/2003 - Eur	Q2 2005 ("average" launch for EU, LA, Canada)
	N/A - Jpn	9/20/2004 - Jpn	
Peak TRx Share, U.S.:	6.5% (patients)	5% (Rx)	Q4 2005 (Average launch for Japan, PAA)
Peak TRx Share, ex-U.S.:	5.4% (patients)	5% (patients)	20% (Neuropathic pain)
Peak Sales, U.S.:	\$285	\$618	5% (Persistent Chronic Pain) same as US assumptions
Peak Sales, ex-U.S.:	\$308	\$310	\$339
Pre-Tax NPV @ 12.5%, ex-U.S.:	\$338	\$305	\$468
Alter-Tax NPV @ 12.5%, U.S.:	\$412	\$813	\$535
Avg. daily dose	50 mg	200 mg	\$316
Target Drug Costing at Launch	\$2,500	\$2,500	150 mg
SMM at Launch (US)	94.8%	97.2%	\$40,000 (base eq.)
SMM at Year 5 (US)			91.6%
			92.2%

* Forecast based on general pain target indication

** Forecast based on neuropathic pain indication and published study in chronic pain

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December 2000
ABT-594 Project Status Report

Project Overview

Description	Metrics Dates		Activity	PARD	
	Date			Plan	Current Revised
DDC Meeting	12/1996 (PPCC)		Phase I Formulation (PIB)*	6/1999	7/1997
Start of first GLP animal tox study	2/1997		Clinical Supplies (PIB) for Molar Extraction	7/1998	7/1998
First dose in human (beg. Phase I)	7/1997		Phase II Formulation (SEC) for IND	7/1998	7/1998
First dose in patient (beg. Phase II)	7/1998		Clinical Supplies (SEC) Shipped	10/1998	10/1998
First dose in Phase III	2/2002 (est.)		(Osteoarthritis, Surgery, Neuropathy)		
Last Patient Last Visit	4/2003 (est.)		Phase III Formulation (HGC) for Bk Study	3/1999	3/1999
NDA Filing	9/2003 (est.)		Phase III Clinical Supplies Manufactured	9/1999	TBD
NDA Approval	9/2004 (est.)		NDA Lots (3) Completed	6/2000	TBD
Europe (EMEA) Filing	9/2003 (est.)		Completion of 1 Year Stability for NDA	7/2001	TBD
Europe (EMEA) Approval	TBD		Formulation Peer Review	10/2001	TBD
Japan Filing	4/2004 (est.)				
Japan Approval	TBD				

* Performed by IDC

SPD

Drug Substance Source/Lot #	KG	Plan	Plan 6/1999 Projected Cost/1g*
D-45L	0.3 KG	3/1997	\$ 200,000
CAPD	5.6 KG	3/1997	\$ 175,000
SICOR	14.9 KG	2/1998	\$ 40,000
SICOR/CAPD	2.5 KG	8/1998	\$ 40,000
Chemsyn PIB Lot	1.0 KG	5/1999	\$ 29,700
Chemsyn Mig. Lot	10.0 KG	10/1999	\$ 29,700
Chemsyn NDA Lot #1	4.85 KG	10/1999	\$ 29,700
Chemsyn NDA Lot #2	4.80 KG	10/1999	\$ 29,700
Chemsyn NDA Lot #3	5.45 KG	10/1999	\$ 29,700

* Target cost of drug substance at launch is \$20,000/kg (Tosylate Salt)

Toxicology

Toxicology Activity	Plan Start 1999	Actual Start Date	Report Completed
Gene Toxicology	2/1997	9/1996	8/1997
Acute Studies	3/1997	4/1997	8/1997
1 Month Rat/Monkey	2/1997	2/1997	11/1997
3 Month Rat/Monkey	7/1997	6/1997	8/1998
3 Month Mouse MTD	10/1997	6/1997	10/1998
SEG I and SEG II	10/1997	7/1997	7/1998
SEG III Rat (post natal development)	-	1/1999	Ongoing
6 Month Rat	1/1998	3/1998	7/1999
1 Year Monkey	6/1998	6/1998	3/2000
Cardiogenicity (2 yr.) Rat	12/1998	8/1998	Ongoing
Cardiogenicity (2 yr.) Mouse	12/1998	11/1998	Ongoing

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December 2000
ABT-594 Project Status Report

Clinical Study Progress

Protocol: M99-114 – A Randomized, Double-Blind, Placebo-Controlled Comparison of the Safety and Efficacy of ABT-594 to Placebo in Subjects with Painful Diabetic Polyneuropathy

Objective: The objective of this study is to compare the safety and analgesic efficacy of 150 µg, 225 µg, and 300 µg twice daily (BID) of ABT-594 to placebo in subjects who have painful distal symmetric diabetic polyneuropathy.

ABT-594 Doses: 150 µg, 225 µg, and 300 µg twice daily (BID)

Comparator Doses: Placebo

Target Enrollment: 320

Target Cost: \$3 MM

Actual Cost: TBD

Status: Ongoing – 267 patients randomized as of 12/31

Major Findings: TBD

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Deposition Exhibit 22

P's Exhibit MB

Part 1



Abbott Laboratories
Interoffice Correspondence

From: Matt Russell
PPD R&D Finance
D-404, AP9 Ext. 5-3482
Date: March 2, 2001

TO: Bob Funck	D-404 AP9	Mike Higgins	D-404 AP9
Tom Woidat	D-404 AP9	Mike Comilla	D-404 AP9
Kirnes Holland	D-404 AP9	Paula Bourland	D-404 AP9
Mischelle Vidakovic	D-404 AP9		

Subject: 2001 PLAN FINAL Reference Package

Attached you will find a copy of the 2001 PLAN FINAL Reference Package. This package has consolidated many of the key schedules we used in the PLAN. Hopefully, this will make referencing numbers from the PLAN easier for everyone. Please let me know if you have any questions.

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Leiden EXHIBIT *22*
FOR I.D. *4-26-07 JAM*

2001 PLAN

FINAL Reference Package

Data as of February 16, 2001

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ABBT 0037510**

2001 PLAN Reference Package

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Note: IDV's were issued in a separate package on 1/5/2001.

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FINAL OpCost

HIGHLY
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2001 PLAN
Pharmaceutical Products Research & Development
Operating Cost Statement
(\$000)

	2000 ACTUALS	09/25/00 FINAL DO AGU	Book 1 ORACLE 2001 PLAN	10/24/2000 PRIOR ADJS	12/01/00-1/30/00 CURRENT ADJS	TOTAL ADJS	FINAL 2001 PLAN	01 PLAN VS DO AGU
Pharmaceutical Discovery	134,725	134,888	145,324	--	(4,688)	(4,688)	140,636	(5,948)
-New Technology (accd # 742-505)	17,438	15,160	16,914	--	(4,468)	(4,468)	12,446	(3,714)
Total Pharmaceutical Discovery	152,163	150,048	162,238	--	(9,156)	(9,156)	153,082	(2,234)
Drug Safety Evaluation	7,541	8,289	10,126	--	(1,507)	(1,507)	8,619	(339)
-Experimental Science	--	970	1,640	--	(1,012)	(1,012)	628	(342)
-Drug Safety Grants	5,788	5,893	5,586	--	(439)	(439)	5,129	(564)
-Clinical Drug Analysis	--	671	365	--	(165)	(165)	200	(472)
-Drug Safety Grants	5,821	7,850	7,209	--	(740)	(740)	6,469	(1,381)
-Toxicology	--	3,511	2,188	--	(702)	(702)	1,486	(2,023)
-Drug Safety Grants	3,817	3,871	3,997	--	127	127	3,724	(177)
-Pathology	--	605	--	--	220	220	220	(385)
-Drug Safety Grants	11,152	10,953	11,219	--	(197)	(197)	11,022	(131)
-Comparative Medicine	880	915	894	--	(87)	(87)	807	(88)
-Admin & Strategic	3,377	3,423	3,787	--	(245)	(245)	3,442	(110)
-Strategic & Exploratory Science	39,176	41,134	42,520	--	(3,208)	(3,208)	39,312	(822)
Total Drug Safety Evaluation	7,541	8,289	10,126	--	(1,507)	(1,507)	8,619	(339)
Medical Affairs	4,181	4,819	5,645	--	(2,703)	(2,703)	2,942	(1,677)
-Genetics/Admin	6,896	6,675	7,454	--	(58)	(58)	7,396	(723)
-Medical Services	--	--	--	--	--	--	--	--
-Clinical Pharm	1,430	1,358	1,542	--	201	201	1,743	(313)
-Outcomes Res/Admin	8,201	8,137	8,845	--	81	81	8,706	(431)
-Phase IV	20,788	18,789	21,288	--	(2,497)	(2,497)	18,789	(2,000)
Total Medical Affairs	4,181	4,819	5,645	--	(2,703)	(2,703)	2,942	(1,677)
Information Mgmt & Technology	1,654	2,055	2,471	--	(77)	(77)	2,464	(1,409)
-Resource Management	44,502	44,763	48,529	--	(1,484)	(1,484)	47,045	(2,723)
-Client Management	--	--	--	--	--	--	--	--
-Technology Management	715	558	840	--	--	--	840	(127)
-Emerging Tech Mgt	--	--	--	--	--	--	--	--
-I M & T Admin	48,671	47,376	51,840	--	(1,491)	(1,491)	50,349	(2,973)
Total Information Mgmt & Technology	1,654	2,055	2,471	--	(77)	(77)	2,464	(1,409)
Development Operations	8,404	8,529	10,487	--	(3,368)	(3,368)	7,119	(1,310)
-Data Management	8,089	8,077	8,026	--	(1,590)	(1,590)	6,436	(1,643)
-Statistics	3,092	3,243	3,807	--	(556)	(556)	3,251	(751)
-Abbott Res & Lib Info Svcs-ARLIS	19,566	16,849	22,320	--	(5,514)	(5,514)	16,806	(4,760)
Total Development Operations	8,404	8,529	10,487	--	(3,368)	(3,368)	7,119	(1,310)
Venture Management	55	172	122	--	(122)	(122)	--	(172)
-Cardiovascular/Diabetes (CD)	5,783	5,381	9,439	--	(707)	(707)	8,732	(2,511)
-Anti - Infective	13,597	9,491	10,203	--	282	282	10,485	(914)
-Anti - Viral	2,373	2,247	3,334	--	2,414	2,414	5,748	(3,375)
-Analgesia/CCM	2,628	2,660	3,750	--	(1,728)	(1,728)	2,021	(607)
-Urology	2,839	2,102	--	--	--	--	--	(2,839)
-Molecular Therapeutics	--	--	--	--	--	--	--	--
-Neuroscience/Quinolones	6,450	6,655	6,574	--	810	810	7,384	(934)
-Oncology & Transplant (Cancer Mgmt)	33,726	28,708	23,622	--	928	928	34,350	(6,622)
Total Venture	16,853	18,312	20,312	--	(600)	(600)	19,852	(1,460)
Administration	62,454	63,142	62,721	--	(3,888)	(3,888)	58,833	(3,621)
Pharm Analytical R&D	9,119	9,008	10,070	--	(648)	(648)	8,422	(697)
Regulatory Affairs	8,990	8,583	14,068	--	(4,398)	(4,398)	8,670	(318)
Phase-I Center	408,706	408,751	440,787	--	(30,512)	(30,512)	410,285	(31,531)
Total Functional	3,560	3,988	6,587	(2,462)	--	(2,462)	4,105	(1,117)
Int'l - Manpower	103,780	108,231	139,785	(26,467)	4,719	(21,757)	118,028	(9,753)
Clinical Grants	--	(848)	--	--	--	--	--	(848)
-Domestic	103,780	108,231	139,785	(26,467)	4,719	(21,757)	118,028	(9,753)
-Adjustment	--	--	--	--	--	--	--	--
Total Clinical Grants	103,780	108,231	139,785	(26,467)	4,719	(21,757)	118,028	(9,753)
Services Purchased	52,599	57,834	63,226	(6,127)	(9,827)	(15,954)	47,272	(10,327)
SPD Purchases	54,891	63,921	63,467	(5,110)	(4,822)	(10,032)	53,435	(11,456)
Corporate Task	--	--	8,100	--	(8,100)	(8,100)	--	(8,100)
Judgment - Internal	--	(10,930)	(27,894)	20,977	12,977	33,954	8,060	(18,900)
Judgment - Published	--	(2,642)	(30,100)	5,000	15,300	20,300	(9,800)	(29,100)
Global reinsurance from Covenants	--	--	--	--	--	--	--	--
Hand Post/Flash to Actual Adjustment	--	--	--	--	--	--	--	--
Other Project Changes:	--	--	--	--	--	--	--	--
Total Project Changes (For Exp Cat)	--	--	--	--	--	--	--	--
Total Gross Expenses	624,636	626,307	663,948	(14,183)	(20,374)	(34,557)	629,385	(11,722)
Services Sold	(248,043)	(251,577)	(253,911)	(2,411)	12,304	9,893	(244,018)	(4,559)
Net Total	376,593	374,730	410,037	(16,666)	(8,070)	(24,664)	385,367	(10,637)
Target	375,593	374,730	410,037	(16,666)	(8,070)	(24,664)	385,367	(10,637)

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2001 PLAN
Pharmaceutical Products Research & Development
Services Purchased
(\$200)

	2000 ACTUALS	09/25/00 FINAL 00 AGU	Book I ORACLE 2001 PLAN	10/24/2000 PRIOR ADJS	12/01/00-10/00/00 CURRENT ADJS	TOTAL ADJS	2001 PLAN	01 PLAN VS 00 AGU
Patents & Trademark	5,504	5,585	5,978	74		74	6,050	(485)
Satellite Copy Charges	556	555	549	(10)		(10)	539	-16
Corp Admin Fixed	4,850	4,995	5,125	102	217	319	5,445	(450)
Corp Cost Pools	5,031	5,175	5,231	(102)	(59)	(161)	5,070	-105
CHMD Services Purchased Fixed (AHD)	193	197	197	(1)		(1)	196	1
PPD Ops Fixed Allocations	2,607	2,522	2,232				2,232	(710)
CENG - Fixed Maintenance from PPD Ops	948	947	899				899	-48
CHEN Variable (ENRS)	323	141	147				147	(6)
CMIS - Purchasing	897	897	733	14		14	747	(150)
CHMS Telecommunications	118	116	118	2	12	14	130	(14)
Fixed L.C. Exp - Admin Services	415	410	427	(1)	(5)	(6)	421	(11)
Corp Eng EHS Fixed Allocation	559	559	587				587	(128)
TOTAL CORPORATE ALLOCATION	21,869	21,878	23,230	78	165	243	23,473	(1,595)
CMIS - Unit of Activity, Fixed - Other	3,012	2,283	3,861	(747)	(447)	(1,194)	2,667	(404)
CMIS - Unit of Activity, Fixed - Aegis	2,062	2,890	2,100				2,100	(790)
PPD Personnel DQA/7	2,512	2,450	2,800		1	1	2,801	(145)
PPD Mtg Ops - Allocation	60	60	60	3		3	63	(3)
PPD Ops QA Int Svcs/Reg Affairs	1,438	1,438	1,942				1,942	(504)
PPD Ops Returned Goods	130	131	136				136	(6)
Project Expense (\$1MM)	10,815	11,208	11,208	(814)	(3,495)	(4,109)	7,099	(4,109)
TOTAL BURDEN FILE	41,898	42,324	45,137	(1,280)	(3,776)	(5,056)	40,081	(2,243)
SPD Pilot Plant Stock Card	20,926	20,960	21,195	4,632	(1,330)	3,302	24,497	(3,571)
SPD Bulk Direct	24,905	33,881	32,862	(12,674)	(2,880)	(15,554)	17,308	(16,553)
Excess Capacity Stock Card	9,160	9,280	9,280	2,932	(802)	2,130	11,810	(2,630)
Subtotal SPD (Other than TAP)	54,991	63,921	63,467	(5,110)	(4,522)	(10,632)	53,435	(10,456)
Grant/Out of Pocket Purchases:								
TAP Bulk Drug (D-TAP)	47	125	125	(41)		(41)	84	(41)
TAP - SPD Manpower & Bulk (D-453)	211	450	450	(205)		(205)	245	(205)
Pharmacogenetics - ADD Allocation								
Misc Expense								
Subtotal (For Exp Cat)	228	675	675	(246)		(246)	329	(246)
Other Purchases:								
Chad Once-A-Day (Global AI Manpower)	10,189	11,393	11,677	2	(3,916)	(3,914)	7,763	(3,630)
Corp Drug User Fees	1,918	1,951	1,838	(831)		(831)	1,207	(744)
Patent to Operations (search services)	200	200						200
D-454 Floor Space (not in functionals)	377	405			182	182	182	(223)
D-454 Deprec (not in functionals)	(501)	1,864	3,033		(49)	(49)	2,984	(1,120)
Molecular Probes	(6)	7	7				7	(13)
Inventory transfer for Protease 2nd Gen		(5,726)						(5,726)
SDG/Other	877	1,287	5,000	(5,000)		(5,000)	6,287	(5,000)
Clinical Supplies (Tricla Genan - PPD Ops)	5	200	200				200	
Aegis Charges	228							
Library (D447) to CHMS			1,500				1,500	
QA (D448) to Operations	1,367	1,448						
Sangstat (Cyclosporine)		(2,400)	(360)		360	360		(2,400)
Sangstat (Sangocyte)		867						867
Gabril Royalty								
Ritonavir/LaRoche Combo								
NOVO Settlement	(1,500)	(1,500)						(1,500)
Metabolan	(888)	(888)						(888)
FLAPVanguard	(818)	(818)						(818)
Sandoz Cost Sharing w/Gabril		(150)						(150)
CI charge from OPS (Cln Val Mgr) + \$49		171						171
Contract Management System	47							
HPD R&D Purchased	411							
Yale Univ. - Survival Patent	2							
Staples Rebates	(66)							(66)
Triangle receipt \$2,935 + \$325 for 1998	(3,482)	(2,914)	(5,381)				(5,381)	(2,467)
Serindole License								
Comdisco	2,440	2,440						2,440
Hydrocodone (BDV-In from HPD)				4,028	(4,028)			
CRD Rebates	(381)			(3,000)		(3,000)	(3,000)	(3,000)
Gabril Reimbursement from Commercial					1,400	1,400	1,400	(1,400)
Other	35							35
Subtotal (For Exp Cat)	10,473	14,935	12,814	(4,501)	(6,051)	(10,552)	5,862	(4,690)
Grand Total	187,590	121,753	126,893	(11,237)	(14,749)	(25,986)	100,707	(21,548)

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2001 PLAN
Pharmaceutical Products Research & Development
Services Sold
(\$000)

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	2000 ACTUALS	09/25/00 00 AGU	Book I ORACLE 2001 PLAN	10/24/2000 PRIOR ADJS	12/01/00-1/30/00 CURRENT ADJS	TOTAL ADJS	2001 PLAN	01 PLAN VS. 00 AGU
General Benefit								
-Global Pharmaceutical	183,788	183,788	193,857	4,813	(12,000)	(7,187)	186,670	(2,902)
Direct Sister Benefit								
-R&D Sci Serv.	3,619	4,478	2,571	55	(242)	(187)	2,384	(2,094)
-Direct Service	4,125	3,794	3,975	(175)	—	(175)	3,800	(5)
Total Direct Support	7,744	8,272	6,546	(120)	(242)	(362)	6,184	(2,558)
Total Int'l Sister Div.	191,512	192,060	200,403	4,693	(12,242)	(7,549)	192,854	(1,342)
TAP Judgment (Positive Controls)								
TAP Bulk Drug (D-TAP)	17	125	125	(41)	—	(41)	84	(91)
TAP - SPD Manpower & Bulk	211	450	450	(205)	—	(205)	245	(205)
TAP - All Other	20,715	23,359	20,170	(575)	261	(314)	19,856	(759)
Total TAP (Incl. Judgment)	20,943	23,934	20,745	(821)	261	(560)	20,185	(1,758)
Domestic Sister Divisions:								
HPD	9,442	10,575	9,689	(950)	95	(855)	8,834	(1,608)
ADD	2,268	1,896	2,340	43	—	43	2,383	(485)
SPD	4,312	4,584	4,810	(719)	818	99	4,909	(222)
ROSS	186	663	1,851	40	64	104	1,855	(1,669)
CPD	3	39	42	—	—	—	42	(39)
MIS	69	71	69	5	—	5	74	(5)
AHD	—	—	—	—	—	—	—	—
CHMS Library Services	—	—	—	—	—	—	—	—
Corp. Eng.	20	2	—	—	—	—	—	18
Subtotal	16,300	17,930	18,801	(1,581)	977	(604)	18,197	(1,103)
Other Sister Divisions:								
Corp. Admin.								
-Corp. Admin.	71	42	23	1	—	1	24	(47)
-Tap Rate Diff	481	481	485	—	—	—	485	(4)
-Symposium Expense	155	155	165	—	—	—	165	(10)
Subtotal CHAD	687	658	673	1	—	1	674	(13)
PPD Product R&D:								
Mfg Support (MG, PM)	14,283	10,780	12,096	119	—	119	12,215	(1,432)
Mfg Support (PV)	124	285	263	—	—	—	263	(22)
PPD Marketing (PS, PS)	4,658	5,414	4,920	—	(1,300)	(1,300)	3,620	(1,038)
Subtotal Other	19,065	16,479	17,279	119	(1,300)	(1,181)	16,098	(2,381)
VAT Refund	537	537	—	—	—	—	—	537
PARD Services Sold Impact (Judgement)	—	—	(3,990)	—	—	—	(3,990)	3,990
Rounding	(1)	(1)	—	—	—	—	—	—
Grand Total	249,843	251,577	253,911	3,411	(12,304)	(9,893)	244,018	(7,559)

Memos:

INPUT Global AI from DetRoll file	N/A	183,788	192,857	N/A	N/A	N/A	186,670
Calculated above	N/A	183,788	193,857	N/A	N/A	N/A	186,670
Key Check (sub 0)	N/A	—	—	N/A	N/A	N/A	—
INPUT From J-Drive File	N/A	210,626	219,877	N/A	N/A	N/A	211,725
Calculated above	N/A	210,626	219,877	N/A	N/A	N/A	211,725
Key Check (sub 0)	N/A	(2)	—	N/A	N/A	N/A	—
Sister Division Amount							
INPUT From DetRoll file	N/A	67,809	64,044	N/A	N/A	N/A	61,338
Calculated above	N/A	67,809	60,054	N/A	N/A	N/A	57,348
Key Check (sub 0)	N/A	—	3,990	N/A	N/A	N/A	3,990
Sister Division Reconciliation							
Sister Division Memos - Oracle	N/A	67,809	60,054	N/A	N/A	N/A	57,348
BP - Blue Plans	N/A	49,144	57,354	N/A	N/A	N/A	104,224
DC - Div Computing/Systems	N/A	13,730	13,850	N/A	N/A	N/A	20,079
DO - Department Overhead	N/A	50	50	N/A	N/A	N/A	50
GO - Global Delivery	N/A	328,237	345,312	N/A	N/A	N/A	299,564
GD - Global Discovery	N/A	96,719	90,107	N/A	N/A	N/A	94,827
P1 - Pharmaceutical Products	N/A	44,593	59,654	N/A	N/A	N/A	38,962
TG - Triangle	N/A	3,011	3,401	N/A	N/A	N/A	5,461
TAP Pass Thru & Bulk Drug not in Orac	N/A	—	—	N/A	N/A	N/A	3,990
Other Judgement	N/A	—	—	N/A	N/A	N/A	674,505
Total	N/A	602,393	631,842	N/A	N/A	N/A	624,471
INPUT Total Per Oracle	N/A	600,093	631,253	N/A	N/A	N/A	624,471
Variance	N/A	3,300	589	N/A	N/A	N/A	34

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2001 PLAN
Pharmaceutical Products Research & Development
Clinical Grants
(\$000's)

02/18/01
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	2000 ACTUALS	09/25/00 FINAL 00 AGU	Book 1 ORACLE 2001 PLAN	10/24/2000 PRIOR ADJS	12/01/00-1/30/00 CURRENT ADJS	TOTAL ADJS	FINAL 2001 PLAN	2001 PLAN 09/25/00 AGU
PPD SERVICE:								
Tiagabine/Gabitril	(80)	2,600	1,900	...	(1,900)	(1,900)	...	...
Ornicel	...	...	4,800	(2,000)	200	(1,800)	3,000	...
Depakote/Depakene	15,319	14,589	11,174	...	(1,733)	(1,733)	9,441	...
r-Pro-LK	(45)	(45)	...	...	...	...	...	...
Fenofibrate (Fournier)	799	(160)	2,250	...	(2,211)	(2,211)	39	...
Hematin	407	...	...	...	600	600	600	...
PharmacoGenetics (Genset)	...	200	200	...	...	...	200	...
TOTAL PPD SERVICE	16,400	17,184	20,324	(2,000)	(5,044)	(7,044)	13,280	...
GLOBAL SERVICE:								
Ritonavir ABT-538	2,715	4,382	1,752	...	(508)	(508)	1,244	...
Protease 2nd Gen ABT-378	30,884	30,362	13,379	...	9,196	9,196	22,575	...
Dopamine	...	...	...	...	...	...	...	...
KCO ABT-598	...	...	...	...	380	380	380	...
ABT-594 (formerly CCM)	2,106	2,800	13,760	(13,051)	356	(12,695)	1,065	...
ABT-089 (formerly ChCM)	...	...	1,628	...	(1,628)	(1,628)	...	...
Clarithromycin	2,314	4,448	4,210	...	(1,270)	(1,270)	2,940	...
Ketolide ABT-773	23,093	23,137	46,382	...	1,023	1,023	47,405	...
Prokinetic Macrolide - Dom	...	...	...	...	...	...	...	...
Zileuton & 2nd Generation	...	...	...	...	...	...	...	...
BPH ABT-980	13,855	14,058	16,678	(11,416)	(5,262)	(16,678)	...	...
Cyclosporine	7,631	7,560	1,300	...	(307)	(307)	993	...
H2G (Medivir)	63	...	...	...	...	...	...	...
Endothelin	2,066	2,440	8,794	...	10,457	10,457	19,251	...
NS 49 Nippon Shinyaku ABT-23	357	633	...	...	...	...	...	...
Bimoclomol (Biores)	...	...	...	...	...	...	...	...
Anti-Mitotic ABT-751	...	...	2,091	...	(1,066)	(1,066)	1,025	...
Hytrin	...	...	...	...	...	...	...	...
FTI (Farnesyltransferase)	...	...	...	...	...	...	...	...
MMPI (Metalloprotease)	116	231	1,346	...	(228)	(228)	1,118	...
Taxane	...	...	...	...	...	...	...	...
TSP Peptide	843	968	1,710	...	(89)	(89)	1,621	...
Quinolone	680	638	5,000	...	...	...	5,000	...
Cox II	157	131	784	...	(653)	(653)	131	...
Neuraminidase	123	...	...	...	...	...	...	...
Adjustment (EVR)	...	(846)	...	...	...	...	...	...
TOTAL GLOBAL SERVICE	87,203	90,942	118,814	(24,467)	10,401	(14,066)	104,748	...
MISC:								
Vitamin D Analog/Iron Dextran	...	76	...	...	...	...	...	...
Isotretinoin/Norvir Investigation	...	...	...	...	...	...	...	...
Adjustments	...	...	...	...	...	...	...	...
Dexmedetomidine/Zempiar (HPD)	177	183	647	...	(647)	(647)	...	...
Tramexone Reformulation	...	...	...	...	...	...	...	...
Biaxin Reformulation	...	...	...	...	...	...	...	...
	177	259	647	...	(647)	(647)
GRAND TOTAL GRANTS	103,780	108,385	139,785	(26,467)	4,710	(21,757)	118,028	...

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2001 PLAN
Pharmaceutical Products Research & Development
Operating Cost Statement
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02/19/01
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	2000 ACTUALS	09/25/00 FINAL 00 AGU	Book 1 ORACLE 2001 PLAN	10/24/2000 PRIOR ADJS	12/01/00-1/30/00 CURRENT ADJS	TOTAL ADJS	FINAL 2001 PLAN	01/01/01 PLAN VS 00 AGU
SDG/Other	877	1,500	3,000	(3,000)		(3,000)	---	---
HIV/Knot/QD/Other	---	1,000	---	---	---	---	---	---
Aegis Insurance	---	952	---	---	---	---	---	---
Genset #1	---	500	---	---	---	---	---	---
IT Productivity Projects	---	---	2,000	(2,000)	---	(2,000)	---	---
Neurosearch FTE \$2530, depr \$20	---	---	---	---	---	---	---	---
Coaction	---	---	---	---	---	---	---	---
SPD IDV Liponavir	---	607	---	---	---	---	---	---
Triangle R&D	---	---	---	---	---	---	---	---
Data Management Absorption	---	1,078	---	---	---	---	---	---
Other New Products	---	2,650	---	---	---	---	---	---
Quinolone In License Payment	---	---	---	---	---	---	---	---
Division Task	---	---	---	---	---	---	---	---
HPD R&D Purchased	---	---	---	---	---	---	---	---
Total SDG/Other	877	8,287	5,000	(5,000)	---	(5,000)	---	8,287

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ABBT 0037517

**PPRD FUNCTIONAL EXPENSE
RECONCILIATIONS MONTH - \$
2001 PLAN**

 6/22/08
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	D1 PLAN	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	TOTAL
Discovery Deals * (742-505)	12,448	—	625	2,015	250	625	2,015	250	625	2,015	250	625	3,151	12,448
All Other Discovery *	140,636	11,481	11,481	11,567	11,527	11,575	11,614	11,614	11,962	12,018	12,038	12,056	11,785	140,636
Subtotal Pharmaceutical Discovery	153,082	11,481	12,106	13,522	11,777	12,200	13,629	11,864	12,587	14,033	12,286	12,681	14,936	153,082
DRUG SAFETY														
Experimental Science	8,819	589	587	714	715	718	732	730	734	721	722	723	723	8,819
Drug Safety Grants (742-200)	828	52	52	52	52	52	52	52	52	53	53	53	53	828
Clinical Drug Analysis	5,129	423	423	424	425	425	431	432	432	428	428	429	429	5,129
Drug Safety Grants	200	17	17	17	17	17	17	17	17	16	16	16	16	200
Toxicology	8,489	524	525	537	537	538	544	545	548	542	543	544	544	8,489
Drug Safety Grants	3,724	299	300	307	307	308	319	320	320	310	311	311	312	3,724
Pathology	220	18	18	18	18	18	18	18	18	19	19	19	19	220
Drug Safety Grants	11,022	916	916	917	917	918	918	919	920	920	921	921	921	11,022
Comparative Medicine	907	75	75	75	75	75	75	76	76	76	76	76	77	907
Advis & Strategic	3,442	284	284	285	285	285	290	290	291	287	287	288	288	3,442
Strategic & Exploratory Science														
Subtotal Drug Safety	39,312	3,210	3,220	3,258	3,281	3,285	3,309	3,315	3,318	3,284	3,287	3,292	3,292	39,312
MEDICAL AFFAIRS														
Administration (Cln Res - CNS)	2,942	228	227	227	247	248	255	255	256	250	250	251	250	2,942
Medical Services	7,398	598	601	612	614	617	618	620	621	622	624	625	627	7,398
Outcomes Research	1,743	124	124	124	138	138	153	153	154	154	154	155	156	1,743
Phase IV	6,708	497	526	546	558	557	587	573	575	578	577	578	578	6,708
Subtotal Medical Affairs	18,789	1,443	1,478	1,523	1,558	1,561	1,593	1,601	1,606	1,603	1,605	1,609	1,611	18,789
Information Mgmt & Technology														
Resource Management	2,404	203	204	204	205	205	206	206	207	207	207	208	203	2,404
Client Management	47,045	3,578	3,321	3,472	3,351	3,518	3,433	3,784	3,673	3,842	4,554	4,492	4,229	47,045
Technology Management	840	69	69	69	70	70	70	70	70	70	71	71	71	840
I M & T Admin	50,349	3,848	3,594	3,745	3,628	3,793	3,708	4,060	3,850	3,919	4,832	4,771	4,503	50,349
Subtotal Information Mgmt & Tech	50,349	3,848	3,594	3,745	3,628	3,793	3,708	4,060	3,850	3,919	4,832	4,771	4,503	50,349
Development Operations														
Data Management	7,119	588	589	590	591	592	593	594	595	596	597	597	597	7,119
Statistcs	6,436	525	526	527	528	530	539	541	542	543	544	545	546	6,436
Abbott Res & Lib Info Svcs-ARUS	3,251	268	268	268	248	249	256	256	256	257	257	248	426	3,251
Subtotal Development Operations	16,806	1,379	1,381	1,383	1,357	1,371	1,388	1,391	1,393	1,396	1,396	1,390	1,569	16,806
VENTURE MANAGEMENT														
Cardiovascular/Diabetes (CD)	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Anti-Infective	8,732	453	487	468	473	480	481	482	3,482	484	485	486	485	8,732
Anti-Viral	10,485	867	868	869	870	871	872	873	873	874	875	876	877	10,485
Analgesia/CCM	5,748	484	489	489	489	490	500	501	450	451	451	451	452	5,748
Urology	2,021	167	167	167	168	168	168	168	168	169	169	170	170	2,021
Molecular Therapeutics	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Neuroscience	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Oncology	7,384	577	578	579	594	617	652	626	629	631	632	632	635	7,384
Subtotal Venture	34,350	2,558	2,578	2,582	2,610	2,636	2,674	2,653	5,603	2,809	2,812	2,815	2,819	34,350
Administration	19,852	1,628	1,629	1,631	1,633	1,635	1,637	1,639	1,641	1,643	1,645	1,647	1,648	19,852
PARO	58,853	4,890	4,881	4,967	4,939	4,971	5,045	4,991	5,042	4,982	5,059	5,045	4,931	58,853
Regulatory Affairs	9,422	673	699	766	786	788	800	811	812	814	815	817	831	9,422
Phase-1 Center	9,870	784	772	777	812	813	815	816	817	819	820	821	824	9,870
TOTAL FUNCTIONAL	410,285	31,852	32,339	34,155	32,367	33,043	34,586	33,141	36,789	35,112	34,359	34,686	37,862	410,285
International Manpower	4,105	287	309	205	287	369	240	452	452	452	431	411	144	4,105
Clinical Grants	118,028	8,273	8,232	10,105	10,458	10,628	11,508	9,804	10,811	10,018	8,787	10,708	10,648	118,028
QASH Services Purchased	100,707	9,076	9,075	8,288	8,742	8,252	6,807	8,252	8,252	8,113	8,717	8,717	8,337	100,707
Corporate Task	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Judgment - Internal	8,060	5,688	2,909	1,944	1,289	2,290	4,725	(1,665)	(3,054)	(2,135)	599	(1,383)	(5,227)	8,060
Judgment - Published	(9,800)	(817)	(817)	(817)	(817)	(817)	(817)	(817)	(817)	(818)	(818)	(818)	(818)	(9,800)
Gabrilis reimbursement from Cosan	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Hand Post/Flash to Actual Adjustment	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Other Project Changes	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Gross PPD R&D Expense	629,385	34,339	32,107	33,889	32,324	33,763	37,185	49,267	52,413	50,742	50,077	52,383	50,948	629,385
QASH Services Sold	(244,018)	(21,185)	(20,215)	(20,854)	(20,328)	(20,715)	(21,863)	(19,091)	(20,005)	(18,708)	(19,579)	(20,458)	(19,877)	(244,018)
Net PPD R&D Expense	385,367	33,173	31,892	33,035	31,996	33,048	35,202	30,206	32,408	31,838	30,498	31,925	30,965	385,367
Minor, Quarterly Net Expense	—	—	—	98,071	—	—	100,248	—	93,653	—	—	—	—	—
This line is least judgment pays to the \$.	385,367	33,173	31,892	33,035	31,996	33,048	35,202	30,206	32,408	31,838	30,498	31,925	30,965	385,367
		8.51%	8.28%	8.56%	8.30%	8.50%	9.13%	7.84%	8.41%	8.05%	7.91%	8.29%	8.04%	

*Does not report based on the actuals reported only Total Pharmaceutical Discovery Inc. Detail is shown here for planning purposes only.

2000 Final AGU	32,133	30,404	35,911	33,138	32,058	45,704	28,913	27,124	29,789	26,703	27,355	26,418	374,730
2000 Actuals	32,133	30,404	35,911	33,138	32,058	45,704	28,913	27,124	29,789	27,085	27,115	27,512	375,593
1999 Actuals (Adjusted for Thrombolytics)	21,427	23,882	25,258	24,305	25,870	24,288	25,842	24,919	23,861	28,343	27,940	40,899	315,443
1998 Actuals	21,582	23,967	27,222	25,313	23,774	25,886	24,495	23,269	26,430	33,783	24,554	42,270	322,725

1/20/2007/Pharmaceuticals/Functional Expense/Summary

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PPRD FUNCTIONAL EXPENSE
RECONCILIATIONS YTD - \$
2001 PLAN

	'01 PLAN	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC
Discovery Deals * (742-505)	12,446	--	625	2,640	2,890	3,515	5,530	6,780	6,405	8,420	8,670	8,295	12,446
All Other Discovery *	140,838	11,481	22,842	34,449	45,976	57,551	68,165	80,779	92,741	104,758	116,795	128,851	140,838
Subtotal Pharmaceutical Discovery	153,082	11,481	23,567	37,089	48,866	61,066	74,695	86,559	99,146	113,178	125,465	138,146	153,082
DRUG SAFETY													
Experimental Science	8,519	689	1,386	2,100	2,815	3,531	4,263	4,996	5,730	6,461	7,173	7,896	8,519
Clinical Drug Analysis	5,129	423	848	1,270	1,695	2,120	2,551	2,983	3,415	3,843	4,271	4,700	5,129
Toxicology	6,469	524	1,049	1,586	2,123	2,661	3,205	3,750	4,296	4,838	5,381	5,925	6,469
Pathology	3,724	299	599	906	1,213	1,521	1,840	2,168	2,490	2,790	3,101	3,412	3,724
Comparative Medicine	11,022	916	1,832	2,749	3,666	4,584	5,502	6,421	7,340	8,260	9,180	10,101	11,022
Admin & Strategic	907	75	150	225	300	375	450	525	600	675	754	830	907
Strategic & Exploratory Science	3,442	284	568	853	1,138	1,423	1,713	2,003	2,294	2,581	2,868	3,156	3,442
Subtotal Drug Safety	39,312	3,210	6,430	9,689	12,950	16,215	19,524	22,838	26,157	29,441	32,728	36,020	39,312
MEDICAL AFFAIRS													
Administration (Clin Res - CNS)	2,942	226	453	680	927	1,175	1,430	1,685	1,941	2,191	2,441	2,692	2,942
Medical Services	7,398	596	1,197	1,809	2,423	3,040	3,658	4,278	4,899	5,522	6,148	6,771	7,398
Outcomes Research	1,743	124	248	369	525	684	817	970	1,124	1,278	1,432	1,587	1,743
Phase IV	6,706	497	1,023	1,559	2,125	2,692	3,249	3,822	4,397	4,973	5,550	6,128	6,706
Subtotal Medical Affairs	16,789	1,443	2,923	4,444	6,000	7,581	9,154	10,755	12,361	13,964	15,569	17,178	18,789
Information Mgmt & Technology													
Resource Management	--	--	--	--	--	--	--	--	--	--	--	--	--
Client Management	2,464	203	407	611	816	1,021	1,226	1,432	1,639	1,846	2,053	2,261	2,464
Technology Management	47,045	3,576	6,967	10,369	13,720	17,236	20,671	24,455	28,128	31,770	36,324	40,816	47,045
IT & T Admin	840	69	138	207	277	347	417	487	557	627	698	769	840
Subtotal Information Mgmt & Tech	50,349	3,848	7,442	11,187	14,813	18,608	22,314	26,374	30,324	34,243	39,075	43,846	50,349
Development Operations													
Data Management	7,119	588	1,177	1,767	2,358	2,958	3,543	4,137	4,732	5,328	5,925	6,522	7,119
Statistics	6,438	525	1,051	1,578	2,106	2,638	3,175	3,716	4,258	4,801	5,345	5,890	6,438
Abbott Res & Lib Info Svcs-ARLIS	3,251	266	532	799	1,048	1,295	1,551	1,807	2,063	2,320	2,577	2,825	3,251
Subtotal Development Operations	16,806	1,379	2,760	4,143	5,519	6,881	8,269	9,660	11,053	12,449	13,847	15,237	16,806
VENTURE MANAGEMENT													
Cardiovascular/Diabetes (CD)	--	--	--	--	--	--	--	--	--	--	--	--	--
Anti-Infective	8,732	453	920	1,388	1,867	2,347	2,828	3,310	3,792	4,275	4,751	5,232	5,713
Anti-Viral	10,465	867	1,735	2,604	3,474	4,345	5,217	6,090	6,963	7,837	8,712	9,588	10,465
Analgesia/CCM	5,748	494	989	1,482	1,971	2,461	2,952	3,443	3,934	4,424	4,915	5,406	5,748
Urology	2,021	167	334	501	668	837	1,005	1,174	1,343	1,512	1,681	1,851	2,021
Molecular Therapeutics	--	--	--	--	--	--	--	--	--	--	--	--	--
Neuroscience	--	--	--	--	--	--	--	--	--	--	--	--	--
Oncology	7,384	577	1,155	1,734	2,313	2,894	3,475	4,056	4,637	5,218	5,799	6,380	7,384
Subtotal Venture	34,350	2,958	5,137	7,719	10,329	12,905	15,639	18,282	20,925	23,568	26,211	28,854	34,350
Administration	19,852	1,528	3,255	4,886	6,519	8,154	9,791	11,430	13,071	14,714	16,359	18,006	19,852
PARC	58,853	4,890	9,771	14,738	19,677	24,648	29,593	34,584	39,726	44,718	49,777	54,822	58,853
Regulatory Affairs	9,422	673	1,372	2,138	2,924	3,722	4,522	5,333	6,145	6,959	7,774	8,591	9,422
Phase-1 Center	9,570	794	1,536	2,313	3,125	3,938	4,753	5,569	6,386	7,205	8,025	8,846	9,570
TOTAL FUNCTIONAL	410,285	31,852	64,191	98,345	130,713	163,758	198,354	231,485	268,264	300,378	337,735	372,423	410,285
Means: % of Total Func, excl. Disc Deals		8.0%	16.0%	24.1%	32.1%	40.2%	48.5%	56.7%	65.8%	74.1%	82.7%	91.3%	100.0%
International Manpower	4,105	287	567	862	1,149	1,519	1,785	2,217	2,688	3,120	3,561	3,961	4,105
Clinical Grants	118,028	8,273	16,505	24,810	33,066	41,892	50,198	59,002	68,813	78,829	88,616	98,382	118,028
QAS4 Services Purchased	100,707	9,075	18,150	27,419	36,180	45,412	54,318	63,571	73,023	82,836	93,053	102,707	100,707
Corporate Task	--	--	--	--	--	--	--	--	--	--	--	--	--
Judgment - Internal	8,060	5,988	8,570	10,520	11,809	14,098	16,823	17,258	14,205	12,070	12,889	11,287	8,060
Judgment - Published	(9,800)	(817)	(1,634)	(2,451)	(3,268)	(4,085)	(4,902)	(5,719)	(6,536)	(7,352)	(8,168)	(8,984)	(9,800)
Global reimbursement from Commerce	--	--	--	--	--	--	--	--	--	--	--	--	--
Hand Post/Flash to Actual Adjustment	--	--	--	--	--	--	--	--	--	--	--	--	--
Other Project Charges:	--	--	--	--	--	--	--	--	--	--	--	--	--
Gross PPD R&D Expense	628,385	54,338	106,445	160,365	212,628	266,392	323,557	372,824	425,237	475,979	526,056	578,439	628,385
QAS5 Services Sold	(244,018)	(21,165)	(41,380)	(62,234)	(82,560)	(103,275)	(125,238)	(144,289)	(164,304)	(184,007)	(203,586)	(224,041)	(244,018)
Net PPD R&D Expense	385,367	33,173	65,065	98,071	130,069	163,117	198,319	228,535	260,933	291,972	322,470	354,398	385,367

* Do not report these lines for actuals; report only Total Pharmaceutical Discovery line. Detail is shown here for planning purposes only.

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PPPD SERVICES PURCHASED
RECONCILIATIONS MONTH - \$
2001 PLAN

EDITION
BUDGET AM

	01 PLAN	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	TOTAL
Patents & Trademark	6,050	504	504	504	504	504	504	504	504	504	504	504	506	6,050
Corp Admin Fixed	5,445	454	454	454	454	454	454	454	454	454	454	454	451	5,445
Corp Cost Pools	5,070	423	423	423	423	423	423	423	423	423	423	423	417	5,070
Satellite Copy Charge	539	45	45	45	45	45	45	45	45	45	45	45	44	539
CHMD Services Purchased Fixed (AHD)	196	16	16	16	16	16	16	16	16	16	16	16	20	196
PPD Ops Fixed Allocations	3,232	269	269	269	269	269	269	269	269	269	269	269	273	3,232
CENG - Fixed Maintenance from PPO O	899	75	75	75	75	75	75	75	75	75	75	75	74	899
CHEN Variable (EWRS)	147	12	12	12	12	12	12	12	12	12	12	12	15	147
CMIS - Purchasing	747	62	62	62	62	62	62	62	62	62	62	62	65	747
CHMS Telecommunications	130	11	11	11	11	11	11	11	11	11	11	11	9	130
Fixed L C Exp - Admin. Services	421	35	35	35	35	35	35	35	35	35	35	35	36	421
Corp Eng EHS Fixed Allocation	597	50	50	50	50	50	50	50	50	50	50	50	57	597
TOTAL CORPORATE ALLOCATION	23,473	1,956	1,956	1,956	1,956	1,956	1,956	1,956	1,956	1,956	1,956	1,956	1,957	23,473
CMIS - Unit of Activity, Fixed - Other	2,667	222	222	222	222	222	222	222	222	222	222	222	225	2,667
CMIS - Unit of Activity, Fixed - Aegis	2,100	175	175	175	175	175	175	175	175	175	175	175	175	2,100
PPD Personnel D0447	2,601	217	217	217	217	217	217	217	217	217	217	217	214	2,601
PPD Mfg Ops - Allocation	63	5	5	5	5	5	5	5	5	5	5	5	6	63
PPD Ops QA Int Sys/Rag Affairs	1,942	162	162	162	162	162	162	162	162	162	162	162	160	1,942
PPD Ops Returned Goods	136	11	11	11	11	11	11	11	11	11	11	11	15	136
Project Expense	7,099	592	592	592	592	592	592	592	592	592	592	592	587	7,099
TOTAL BURDEN FILE	40,081	3,340	3,340	3,340	3,340	3,340	3,340	3,340	3,340	3,340	3,340	3,340	3,341	40,081
SPD Pilot Plant Stock Card	24,497	2,042	2,042	2,042	2,042	2,042	2,042	2,042	2,042	2,042	2,042	2,042	2,035	24,497
SPD Bulk Direct (Chem/Ferm)	17,328	1,444	1,444	1,444	1,444	1,444	1,444	1,444	1,444	1,444	1,444	1,444	1,444	17,328
Excess Capacity Stock Card	11,610	958	958	958	958	958	958	958	958	958	958	958	952	11,610
Subtotal SPD (Other than TAP)	53,435	4,454	4,454	4,454	4,454	4,454	4,454	4,454	4,454	4,454	4,454	4,454	4,441	53,435
TAP Bulk Drug (D-TAP)	84	7	7	7	7	7	7	7	7	7	7	7	7	84
TAP - SPD Manpower & Bulk (D-453)	245	20	20	20	20	20	20	20	20	20	20	20	25	245
Pharmacogenetics -- ADD Allocation	--	--	--	--	--	--	--	--	--	--	--	--	--	--
Misc Expense	--	--	--	--	--	--	--	--	--	--	--	--	--	--
Subtotal (For Exp Cat)	329	27	27	27	27	27	27	27	27	27	27	27	32	329
Other Purchases:														
Clini Once-A-Day (Global AI Manpower)	7,763	573	573	573	573	483	483	483	483	483	483	483	487	7,763
Corp Drug User Fees	1,207	--	--	--	--	--	--	--	--	1,207	--	--	--	1,207
Patent to Operations (search services)	--	--	--	--	--	--	--	--	--	--	--	--	--	--
D-AS4 Floor Space (not in functionals)	182	15	15	15	15	15	15	15	15	15	15	15	17	182
D-AS4 Deprec (not in functionals)	2,984	249	249	249	249	249	249	249	249	249	249	249	245	2,984
Molecular Probes	7	--	--	--	--	--	--	--	--	--	--	--	7	7
Inventory transfer for Protease 2nd Gen	--	--	--	--	--	--	--	--	--	--	--	--	--	--
SDG/Other	--	--	--	--	--	--	--	--	--	--	--	--	--	--
Clinical Supplies (Tricia Geran -PPD Op	200	17	17	17	17	17	17	17	17	16	16	16	16	200
Aegis Charges	--	--	--	--	--	--	--	--	--	--	--	--	--	--
Library (D441) to CHMS	--	--	--	--	--	--	--	--	--	--	--	--	--	--
QA (D44N) to Operations	1,500	--	--	--	--	--	--	--	--	--	--	--	1,500	1,500
Sangstat (Cyclosporine)	--	--	--	--	--	--	--	--	--	--	--	--	--	--
Sangstat (Sangcyra)	--	--	--	--	--	--	--	--	--	--	--	--	--	--
Gabitril Royalty	--	--	--	--	--	--	--	--	--	--	--	--	--	--
Ribonavirin/LaRoche Combo	--	--	--	--	--	--	--	--	--	--	--	--	--	--
NOVO Settlement	--	--	--	--	--	--	--	--	--	--	--	--	--	--
Metabolix	--	--	--	--	--	--	--	--	--	--	--	--	--	--
FLAP/Vanguard	--	--	--	--	--	--	--	--	--	--	--	--	--	--
Sandoz Cost Sharing w/Gabitril	--	--	--	--	--	--	--	--	--	--	--	--	--	--
CI charge from OPS (Clin Val Mgr) + \$4	--	--	--	--	--	--	--	--	--	--	--	--	--	--
Triangle receipt \$2,935 +\$325 for 1999	(5,381)	--	--	(807)	--	--	(1,345)	--	--	(1,345)	--	--	(1,884)	(5,381)
Comdisco	--	--	--	--	--	--	--	--	--	--	--	--	--	--
Hydrocodone (RDV-in from HPI)	--	--	--	--	--	--	--	--	--	--	--	--	--	--
CRO Rebates	(3,000)	--	--	--	(333)	(333)	(333)	(333)	(333)	(333)	(334)	(334)	(334)	(3,000)
Gabitril Reimbursement from Commercial	1,400	--	--	--	--	--	--	--	--	--	467	467	466	1,400
Other	--	--	--	--	--	--	--	--	--	--	--	--	--	--
Grand Total	100,797	9,076	9,076	9,076	9,742	8,252	6,907	8,252	8,252	8,113	8,717	8,717	8,334	100,797

(2,637)

L:\CFO\PLANNING\2001 PLAN\001 FINAL Opndr.LWK

HIGHLY

CONFIDENTIAL
ABBT 0037520

8

PPRD SERVICES PURCHASED
RECONCILIATIONS YTD - \$
2001 PLAN

02/22/08
09:07 AM

	01 PLAN	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC
Patents & Trademark	6,050	504	1,008	1,512	2,016	2,520	3,024	3,528	4,032	4,536	5,040	5,544	6,050
Corp Admin Fixed	5,445	454	908	1,362	1,816	2,270	2,724	3,178	3,632	4,086	4,540	4,994	5,445
Corp Cost Pools	5,070	423	846	1,269	1,692	2,115	2,538	2,961	3,384	3,807	4,230	4,653	5,070
Satellite Copy Charge	539	45	90	135	180	225	270	315	360	405	450	495	539
CHMD Services Purchased Fixed (AHD)	196	16	32	48	64	80	96	112	128	144	160	176	196
PPD Ops Fixed Allocations	3,232	269	538	807	1,076	1,345	1,614	1,883	2,152	2,421	2,690	2,959	3,232
CENG - Fixed Maintenance from PPD O	899	75	150	225	300	375	450	525	600	675	750	825	899
CHEN Variable (EWRS)	147	12	24	36	48	60	72	84	96	108	120	132	147
CHMS - Purchasing	747	62	124	186	248	310	372	434	496	558	620	682	747
CHMS Telecommunications	130	11	22	33	44	55	66	77	88	99	110	121	130
Fixed I.C. Exp - Admin. Services	421	35	70	105	140	175	210	245	280	315	350	385	421
Corp Eng EHS Fixed Allocation	597	50	100	150	200	250	300	350	400	450	500	550	597
TOTAL CORPORATE ALLOCATION	23,473	1,956	3,912	5,868	7,824	9,789	11,736	13,692	15,648	17,604	19,560	21,516	23,473
CHMS - Unit of Activity, Fixed - Other	2,667	222	444	666	888	1,110	1,332	1,554	1,776	1,998	2,220	2,442	2,667
CHMS - Unit of Activity, Fixed - Argis	2,100	175	350	525	700	875	1,050	1,225	1,400	1,575	1,750	1,925	2,100
PPD Personnel DOA47	2,601	217	434	651	868	1,085	1,302	1,519	1,736	1,953	2,170	2,387	2,601
PPD Mfg Ops - Allocation	53	5	10	15	20	25	30	35	40	45	50	55	53
PPD Ops QA Inf Svcs/Reg Affairs	1,942	162	324	486	648	810	972	1,134	1,296	1,458	1,620	1,782	1,942
PPD Ops Returned Goods	136	11	22	33	44	55	66	77	88	99	110	121	136
Project Expense	7,099	592	1,184	1,776	2,368	2,960	3,552	4,144	4,736	5,328	5,920	6,512	7,099
TOTAL BURDEN FEE	40,081	3,340	6,680	10,020	13,360	16,700	20,040	23,380	26,720	30,060	33,400	36,740	40,081
SPD Pilot Plant Stock Card	24,497	2,042	4,084	6,126	8,168	10,210	12,252	14,294	16,336	18,378	20,420	22,462	24,497
SPD Bulk Direct (Chem/Ferms)	17,328	1,444	2,888	4,332	5,776	7,220	8,664	10,108	11,552	12,996	14,440	15,884	17,328
Excess Capacity Stock Card	11,619	968	1,936	2,904	3,872	4,840	5,808	6,776	7,744	8,712	9,680	10,648	11,619
Subtotal SPD (Other than TAP)	53,435	4,454	8,908	13,362	17,816	22,270	26,724	31,178	35,632	40,086	44,540	48,994	53,435
TAP Bulk Drug (D-TAP)	84	7	14	21	28	35	42	49	56	63	70	77	84
TAP - SPD Marpower & Bulk (D-453)	245	20	40	60	80	100	120	140	160	180	200	220	245
Pharmacogenetics - ADD Allocation	---	---	---	---	---	---	---	---	---	---	---	---	---
Misc Expense	---	---	---	---	---	---	---	---	---	---	---	---	---
Subtotal (For Exp Cat)	329	27	54	81	108	135	162	189	216	243	270	297	329
Other Purchases:	---	---	---	---	---	---	---	---	---	---	---	---	---
Cost Once-A-Day (Global AI Marpower)	7,763	973	1,947	2,920	3,893	4,866	5,840	6,813	7,786	8,759	9,732	10,705	11,678
Corp Drug User Fees	1,207	---	---	---	---	---	---	---	---	---	---	---	---
Patent to Operations (search services)	---	---	---	---	---	---	---	---	---	---	---	---	---
D-A54 Floor Space (not in functionals)	182	15	30	45	60	75	90	105	120	135	150	165	182
D-A54 Deprec (not in functionals)	2,884	249	498	747	996	1,245	1,494	1,743	1,992	2,241	2,490	2,739	2,988
Molecular Probes	7	---	---	---	---	---	---	---	---	---	---	---	---
Inventory transfer for Protease 2nd Gen	---	---	---	---	---	---	---	---	---	---	---	---	---
SDG/Other	---	---	---	---	---	---	---	---	---	---	---	---	---
Clinical Supplies (Tritia Geran - PPD Op	200	17	34	51	68	85	102	119	136	152	168	184	200
Argis Charges	---	---	---	---	---	---	---	---	---	---	---	---	---
Library (D441) to CHMS	---	---	---	---	---	---	---	---	---	---	---	---	---
QA (D44N) to Operations	1,500	---	---	---	---	---	---	---	---	---	---	---	1,500
Sangstat (Cyclosporine)	---	---	---	---	---	---	---	---	---	---	---	---	---
Sangstat (Sangcyte)	---	---	---	---	---	---	---	---	---	---	---	---	---
Gabril Royalty	---	---	---	---	---	---	---	---	---	---	---	---	---
Ribonvir/LaRoche Combo	---	---	---	---	---	---	---	---	---	---	---	---	---
NOVO Settlement	---	---	---	---	---	---	---	---	---	---	---	---	---
Metabolex	---	---	---	---	---	---	---	---	---	---	---	---	---
FLAP/Vanguard	---	---	---	---	---	---	---	---	---	---	---	---	---
Sanofi Cost Sharing w/Gabril	---	---	---	---	---	---	---	---	---	---	---	---	---
Cl charge from OPS (Cin Val Mgr) + \$4	---	---	---	---	---	---	---	---	---	---	---	---	---
Triangle receipt \$2,535 + \$325 for 1999	(5,381)	---	---	(807)	(807)	(807)	(2,152)	(2,152)	(2,152)	(3,497)	(3,497)	(3,497)	(5,381)
Comdisco	---	---	---	---	---	---	---	---	---	---	---	---	---
Hydrocodone (IDV-in from HPD)	---	---	---	---	---	---	---	---	---	---	---	---	---
CRO Rebates	(3,000)	---	---	---	(333)	(666)	(999)	(1,332)	(1,665)	(1,998)	(2,332)	(2,666)	(3,000)
Gabril Reimbursement from Commercial	1,400	---	---	---	---	---	---	---	---	---	467	934	1,400
Other	---	---	---	---	---	---	---	---	---	---	---	---	---
Grand Total	100,707	9,075	18,151	26,419	35,161	43,413	50,321	58,573	66,825	74,938	83,056	92,373	100,707

HIGHLY
CONFIDENTIAL
ABBT 0037521

PPRD SERVICES SOLD
RECONCILIATIONS MONTH - \$
2001 PLAN

EXPENSE
2002 AM

	01 PLAN	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	TOTAL
% RATE - ACTUALS														
% RATE - MONTHLY PROJECTION														
Cumulative % Rate														
% RATE - ADJUSTED PROJECTION														
AI GLOBAL PHARMACEUTICAL	186,670	16,385	15,435	16,074	15,546	15,935	17,183	14,280	15,224	14,922	14,798	15,674	15,214	186,670
Direct Sister Benefit														
R&D Scientific Service (Fixed)	2,384	199	199	199	199	199	199	199	199	199	199	199	195	2,384
Direct Service	3,800	317	317	317	317	317	317	317	317	317	317	317	313	3,800
Total Direct Sister Benefit	6,184	516	516	516	516	516	516	516	516	516	516	516	508	6,184
Total Indl Sister Division	192,854	16,901	16,951	16,590	16,062	16,451	17,599	14,796	15,740	15,438	15,314	16,190	15,722	192,854
TAP - SPD Manpower	245	20	20	20	20	20	20	20	20	20	20	20	25	245
TAP - Judgment (Positive Controls)														
TAP - Bulk Drug	84	7	7	7	7	7	7	7	7	7	7	7	7	84
TAP - All Other	19,856	1,655	1,655	1,655	1,655	1,655	1,655	1,655	1,655	1,655	1,655	1,655	1,651	19,856
Total TAP	20,185	1,682	1,682	1,682	1,682	1,682	1,682	1,682	1,682	1,682	1,682	1,682	1,683	20,185
Domestic Sister Divisions														
HPD	8,634	736	736	736	736	736	736	736	736	736	736	736	738	8,634
ADD	2,383	199	199	199	199	199	199	199	199	199	199	199	194	2,383
SPD	4,909	409	409	409	409	409	409	409	409	409	409	409	410	4,909
ROSS	1,955	163	163	163	163	163	163	163	163	163	163	163	162	1,955
CPD	42	4	4	4	4	4	4	4	4	4	4	4	(2)	42
MIS	74	6	6	6	6	6	6	6	6	6	6	6	8	74
AHD (AHS Abbott Health Systems)														
CHMS Library Charges														
Corp Eng														
Total Domestic Sister Division	16,197	1,517	1,517	1,517	1,517	1,517	1,517	1,517	1,517	1,517	1,517	1,517	1,510	16,197
Other Sister Divisions:														
Corp Administration														
Corp. Admin.	24	2	2	2	2	2	2	2	2	2	2	2	2	24
TAP Rate Diff (Fixed)	485	40	40	40	40	40	40	40	40	40	40	40	45	485
Symposium Expense (Fixed)	165	14	14	14	14	14	14	14	14	14	14	14	11	165
Subtotal CHAD	674	56	56	56	56	56	56	56	56	56	56	56	58	674
PPD Product R&D														
Mfg Support (MC, PM)	12,215	1,018	1,018	1,018	1,018	1,018	1,018	1,018	1,018	1,018	1,018	1,018	1,017	12,215
Mfg Support (PV)	263	22	22	22	22	22	22	22	22	22	22	22	21	263
PPD Marketing (P5, P6) (Inc Cephalon)	3,620	302	302	302	302	302	302	302	302	302	302	302	298	3,620
Subtotal Other	16,098	1,342	1,342	1,342	1,342	1,342	1,342	1,342	1,342	1,342	1,342	1,342	1,336	16,098
VAT Refund														
PARC Services Sold Impact (Judgment)	(3,980)	(333)	(333)	(333)	(333)	(333)	(333)	(332)	(332)	(332)	(332)	(332)	(332)	(3,980)
Rounding														
GRAND TOTAL	244,018	21,165	20,215	20,854	20,326	20,715	21,963	19,061	20,005	19,703	19,579	20,455	19,977	244,018
Memo: Excluding Global - \$		4,780	4,780	4,780	4,780	4,780	4,780	4,781	4,781	4,781	4,781	4,781	4,783	57,348
Quarterly - \$				14,340			14,340						14,325	57,348
Excluding Global - % of Qtr				25.0%			25.0%						25.0%	
Excluding Global - % Dec													8.3%	

LICORP/PLANNING/PPRD PLAN/2001 FINAL Qtr/2004

HIGHLY
CONFIDENTIAL
ABBT 0037522

10

PPRD SERVICES SOLD
RECONCILIATIONS YTD - \$
2001 PLAN

02/19/01
12:57 PM

	01 PLAN	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC
AI GLOBAL PHARMACEUTICAL	186,670	16,385	31,820	47,894	63,440	79,375	96,553	110,838	126,062	140,944	155,782	171,456	186,670
Direct Sister Benefit													
R&D Scientific Service (fixed)	2,384	199	398	597	796	995	1,194	1,393	1,592	1,791	1,990	2,189	2,384
Direct Service	3,800	317	634	951	1,268	1,585	1,902	2,219	2,536	2,853	3,170	3,487	3,800
Total Direct Sister Benefit	6,184	516	1,032	1,548	2,064	2,580	3,096	3,612	4,128	4,644	5,160	5,676	6,184
Total Ind Sister Division	192,854	16,901	32,852	49,442	65,504	81,955	99,654	114,450	130,190	145,528	160,942	177,132	192,854
TAP - SPD Manpower	245	20	40	60	80	100	120	140	160	180	200	220	245
TAP - Judgment	—	—	—	—	—	—	—	—	—	—	—	—	—
TAP - Bulk	84	7	14	21	28	35	42	49	56	63	70	77	84
TAP - All Other	19,056	1,655	3,210	4,865	6,520	8,175	9,830	11,485	13,140	14,795	16,450	18,105	19,056
Total TAP	20,185	1,682	3,264	4,906	6,528	8,110	9,892	11,774	13,456	15,138	16,820	18,502	20,185
Domestic Sister Divisions													
HPD	8,834	736	1,472	2,208	2,944	3,680	4,416	5,152	5,888	6,624	7,360	8,096	8,834
ADD	2,383	199	398	597	796	995	1,194	1,393	1,592	1,791	1,990	2,189	2,383
SPD	4,909	409	818	1,227	1,636	2,045	2,454	2,863	3,272	3,681	4,090	4,499	4,909
ROSS	1,955	163	326	489	652	815	978	1,141	1,304	1,467	1,630	1,793	1,955
CPD	42	4	8	12	16	20	24	28	32	36	40	44	42
MIS	74	6	12	18	24	30	36	42	48	54	60	66	74
AHD (AHS Abbott Health Systems)	—	—	—	—	—	—	—	—	—	—	—	—	—
CHMS Library Charges	—	—	—	—	—	—	—	—	—	—	—	—	—
Corp Eng	—	—	—	—	—	—	—	—	—	—	—	—	—
Total Domestic Sister Division	18,197	1,517	3,034	4,551	6,068	7,585	9,102	10,619	12,136	13,653	15,170	16,687	18,197
Other Sister Divisions:													
Corp Administration													
Corp. Admin.	24	2	4	6	8	10	12	14	16	18	20	22	24
TAP Rate Off	485	40	80	120	160	200	240	280	320	360	400	440	485
Symposium Expense	165	14	28	42	56	70	84	98	112	126	140	154	165
Subtotal CHAD	674	56	112	168	224	280	336	392	448	504	560	616	674
PPD Product R&D													
Mfg Support (MC, PM)	12,215	1,018	2,036	3,054	4,072	5,090	6,108	7,126	8,144	9,162	10,180	11,198	12,215
Mfg Support (PV)	263	22	44	66	88	110	132	154	176	198	220	242	263
PPD Marketing (P5, P6) (Inc Cephalon)	3,620	292	584	876	1,168	1,460	1,752	2,044	2,336	2,628	2,920	3,212	3,620
Subtotal Other	16,098	1,342	2,684	4,026	5,368	6,710	8,052	9,394	10,736	12,078	13,420	14,762	16,098
VAT Refund	—	—	—	—	—	—	—	—	—	—	—	—	—
PPRD Services Sold Impact (Judgment Rounding)	(3,990)	(333)	(666)	(999)	(1,332)	(1,665)	(1,998)	(2,330)	(2,662)	(2,994)	(3,326)	(3,659)	(3,990)
GRAND TOTAL	244,018	21,165	41,380	62,234	82,560	103,275	125,238	144,299	164,304	184,007	203,586	224,041	244,018

LG:GROUP/PLANNING/COBOL PLAN/2001 PLAN, Output:YTD

HIGHLY
CONFIDENTIAL
ABBT 0037523

PPPD CLINICAL GRANTS
RECONCILIATIONS MONTH - 1
2001 PLAN

gross
net

	01 PLAN	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	DEC ADJ	TOTAL
PPD SERVICE:															
Tigabine/Cybal	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Ornicel	3,000	—	—	—	—	—	—	—	—	500	500	500	500	—	3,000
Dapsone/Dapsone	8,441	723	(30)	1,179	1,180	1,180	1,180	1,181	608	608	373	373	372	—	8,441
r-Pro-UK	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Famotidine (Famotid)	38	38	—	—	—	—	—	—	—	—	—	—	—	—	38
Vericel	520	—	128	128	128	128	128	—	—	—	—	—	—	—	520
PharmaciaGenetics (Casse)	200	—	—	28	28	28	28	28	28	28	28	28	28	—	200
TOTAL PPD SERVICE	12,299	761	32	1,315	1,336	1,336	1,336	1,386	1,801	1,238	933	933	932	—	12,299
GLOBAL SERVICE:															
Blonazet ABT-539	1,244	259	(142)	108	108	108	108	108	108	108	108	108	108	—	1,244
Protease 2nd Gen ABT-378	22,575	120	1,818	1,892	2,801	2,243	2,239	2,168	1,353	1,806	1,806	1,806	1,806	—	22,575
Dapsone	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
KCO ABT-598	380	—	38	101	128	128	128	128	128	128	48	48	18	—	380
ABT-594 (formerly CCH)	1,865	100	38	101	128	128	128	128	128	128	48	48	18	—	1,865
ABT-598 (formerly CCH)	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Celebrex	2,840	172	172	260	260	260	260	260	259	259	259	259	259	—	2,840
Kaletra ABT-773	47,405	4,347	4,847	4,825	4,860	4,860	4,860	3,403	3,403	3,386	333	3,385	3,386	—	47,405
Prokinetic Macrolide - Dem	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Zincate & 2nd Generation	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
BPH ABT-980	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Cyclosporine	850	484	35	125	115	115	35	35	35	34	—	—	—	—	850
ESG (Medivir)	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Endovate	18,251	1,035	1,035	1,035	1,035	1,035	1,849	1,897	1,897	1,897	2,178	2,178	2,178	—	18,251
NS 49 Nippon Shinyaku ABT-23	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Blonazet (Blonaz)	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Anti-Helic ABT-751	1,025	—	—	—	75	75	125	125	125	125	125	125	125	—	1,025
Hydral	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
FTI (Famotidine/Protonase)	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
MMF (Methotrexate)	1,118	84	84	84	84	84	114	114	114	114	114	114	114	—	1,118
Tamoxifen	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
TSP Peptide	1,821	116	116	116	88	115	168	168	168	165	165	165	165	—	1,821
Doxilone	5,009	229	159	158	308	289	289	289	628	628	477	894	894	—	5,009
Dac II	131	85	66	—	—	—	—	—	—	—	—	—	—	—	131
Neuraminidase	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Adjuvant (EVN)	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
TOTAL GLOBAL SERVICE	104,748	7,811	8,200	8,796	8,136	8,386	15,186	8,894	8,788	8,734	8,773	8,654	8,654	—	104,748
NSC:															
Vaccine D Analog/Protein Dextran	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Immunomodulator/Investigation	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Adjuvants	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Dexamethasone/Zincifer BHPD	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Tamoxifen/Protein/Investigation	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Biotech Reformulation	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
GRAND TOTAL GRANTS	116,826	8,773	8,232	10,125	10,625	10,625	11,506	9,804	9,811	10,036	9,787	10,726	10,646	—	116,826
— Quarterly Percentages				22.5%						26.0%		21.1%			100.0%
Actuals							11,908								
Total Global Grants															
Total Other Domestic Grants															
Total Other Grants															
Total Grants															
Key Checks (see 8)															
Direct System (Excel as of 12/1/07)															
Difference															

12/1/07 10:00 AM (GMT-05:00) PPWD Plan, Domestic

CONFIDENTIAL
ABBT 0037524

12

PPRD CLINICAL GRANTS
RECONCILIATIONS - YTD \$
2001 PLAN

	DI PLAN	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC
PPD SERVICE:													
Targobins/Gablin	3,000	—	—	—	—	—	—	—	600	1,200	1,800	2,400	3,000
Onvical	9,441	723	635	1,814	2,894	4,174	5,254	6,534	7,715	8,323	8,898	9,069	9,441
Dapivastatin/Dapivastatin	—	—	—	—	—	—	—	—	—	—	—	—	—
r-Pro-UK	39	39	39	39	39	39	39	39	39	39	39	39	39
Fenofibrate (Fenofibrate)	600	—	120	240	360	480	600	600	600	600	600	600	600
Marufin	200	—	—	20	40	60	80	100	120	140	160	180	200
PharmacoGenetics (Genetics)	—	—	—	—	—	—	—	—	—	—	—	—	—
TOTAL PPD SERVICE	13,280	792	794	2,113	3,433	4,753	6,073	7,273	8,674	10,302	11,285	12,238	13,280
GLOBAL SERVICE:													
Ribonvir ABT-538	1,244	299	157	264	375	484	593	702	811	920	1,028	1,136	1,244
Protease 2nd Gen ABT-378	22,575	120	1,834	3,830	5,831	8,074	10,313	12,479	14,634	16,547	18,583	20,578	22,575
Dopamine	—	—	—	—	—	—	—	—	—	—	—	—	—
KCO ABT-598	380	—	—	—	—	—	—	—	—	—	—	180	380
ABT-598 (formerly CCM)	1,065	100	130	231	351	471	591	711	831	951	899	1,047	1,065
ABT-598 (formerly CCM)	—	—	—	—	—	—	—	—	—	—	—	—	—
Carbamazepine	2,940	172	244	304	364	424	484	544	604	664	724	784	844
Ketide ABT-772	47,405	4,847	9,694	14,541	19,388	24,235	29,082	33,929	38,776	43,623	48,470	53,317	58,164
Prokinetic Macrolide - Dom	—	—	—	—	—	—	—	—	—	—	—	—	—
Zinc & 2nd Generation	—	—	—	—	—	—	—	—	—	—	—	—	—
BPH ABT-600	—	—	—	—	—	—	—	—	—	—	—	—	—
Cyclosporine	893	464	499	534	569	604	639	674	709	744	779	814	849
KCO (Macrolide)	—	—	—	—	—	—	—	—	—	—	—	—	—
Endothelin	18,251	1,025	2,070	3,115	4,160	5,205	6,250	7,295	8,340	9,385	10,430	11,475	12,520
NS 40 Nippon Shinyaku ABT-323	—	—	—	—	—	—	—	—	—	—	—	—	—
Bimoclone (Bimoclone)	1,025	—	—	—	75	150	225	300	375	450	525	600	675
Anti-Macrolide ABT-751	—	—	—	—	—	—	—	—	—	—	—	—	—
Hydro	1,118	64	128	192	256	320	384	448	512	576	640	704	768
LMPI (Metabolite)	—	—	—	—	—	—	—	—	—	—	—	—	—
Taxane	—	—	—	—	—	—	—	—	—	—	—	—	—
TSP Peptide	1,621	116	232	348	464	580	696	812	928	1,044	1,160	1,276	1,392
Quinolone	5,000	229	368	507	646	785	924	1,063	1,202	1,341	1,480	1,619	1,758
Cas 8	131	65	131	196	261	326	391	456	521	586	651	716	781
Neuroleptics	—	—	—	—	—	—	—	—	—	—	—	—	—
Adjustment (EVR)	—	—	—	—	—	—	—	—	—	—	—	—	—
TOTAL GLOBAL SERVICE	104,748	7,611	15,711	24,497	33,633	42,939	52,125	61,229	70,239	79,227	88,221	97,094	104,748
Vitamin D Analogues Dextran	—	—	—	—	—	—	—	—	—	—	—	—	—
Isotretinoin/Novartis Investigation	—	—	—	—	—	—	—	—	—	—	—	—	—
Adjustments	—	—	—	—	—	—	—	—	—	—	—	—	—
Docetaxel/Novartis/Zenpep (PPD)	—	—	—	—	—	—	—	—	—	—	—	—	—
Taxane Reformation	—	—	—	—	—	—	—	—	—	—	—	—	—
Slash Reformation	—	—	—	—	—	—	—	—	—	—	—	—	—
GRAND TOTAL GRANTS	118,028	8,273	15,565	24,510	33,668	42,992	52,196	61,300	70,296	79,296	88,296	97,094	104,748

LOCAL PLAN/GRANT PLAN/PPD PLAN/GRANT PLAN

PPRD CLINICAL GRANTS RECONCILIATIONS - YTD \$ 2001 PLAN

PPRD CLINICAL GRANTS RECONCILIATIONS - YTD \$ 2001 PLAN

HCHLN

CONFIDENTIAL
ABBT 0037525

13

Pharmaceutical Products Research & Development
Grand System
2001 Plant Closing

Item #	Product	Product Description	Project Name	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total	Year	End
10780	10780-001	10780-001	10780-001															
10781	10781-001	10781-001	10781-001															
10782	10782-001	10782-001	10782-001															
10783	10783-001	10783-001	10783-001															
10784	10784-001	10784-001	10784-001															
10785	10785-001	10785-001	10785-001															
10786	10786-001	10786-001	10786-001															
10787	10787-001	10787-001	10787-001															
10788	10788-001	10788-001	10788-001															
10789	10789-001	10789-001	10789-001															
10790	10790-001	10790-001	10790-001															
10791	10791-001	10791-001	10791-001															
10792	10792-001	10792-001	10792-001															
10793	10793-001	10793-001	10793-001															
10794	10794-001	10794-001	10794-001															
10795	10795-001	10795-001	10795-001															
10796	10796-001	10796-001	10796-001															
10797	10797-001	10797-001	10797-001															
10798	10798-001	10798-001	10798-001															
10799	10799-001	10799-001	10799-001															
10800	10800-001	10800-001	10800-001															
10801	10801-001	10801-001	10801-001															
10802	10802-001	10802-001	10802-001															
10803	10803-001	10803-001	10803-001															
10804	10804-001	10804-001	10804-001															
10805	10805-001	10805-001	10805-001															
10806	10806-001	10806-001	10806-001															
10807	10807-001	10807-001	10807-001															
10808	10808-001	10808-001	10808-001															
10809	10809-001	10809-001	10809-001															
10810	10810-001	10810-001	10810-001															
10811	10811-001	10811-001	10811-001															
10812	10812-001	10812-001	10812-001															
10813	10813-001	10813-001	10813-001															
10814	10814-001	10814-001	10814-001															
10815	10815-001	10815-001	10815-001															
10816	10816-001	10816-001	10816-001															
10817	10817-001	10817-001	10817-001															
10818	10818-001	10818-001	10818-001															
10819	10819-001	10819-001	10819-001															
10820	10820-001	10820-001	10820-001															
10821	10821-001	10821-001	10821-001															
10822	10822-001	10822-001	10822-001															
10823	10823-001	10823-001	10823-001															
10824	10824-001	10824-001	10824-001															
10825	10825-001	10825-001	10825-001															
10826	10826-001	10826-001	10826-001															
10827	10827-001	10827-001	10827-001															
10828	10828-001	10828-001	10828-001															
10829	10829-001	10829-001	10829-001															
10830	10830-001	10830-001	10830-001															
10831	10831-001	10831-001	10831-001															
10832	10832-001	10832-001	10832-001															
10833	10833-001	10833-001	10833-001															
10834	10834-001	10834-001	10834-001															
10835	10835-001	10835-001	10835-001															
10836	10836-001	10836-001	10836-001															
10837	10837-001	10837-001	10837-001															
10838	10838-001	10838-001	10838-001															
10839	10839-001	10839-001	10839-001															
10840	10840-001	10840-001	10840-001															
10841	10841-001	10841-001	10841-001															
10842	10842-001	10842-001	10842-001															
10843	10843-001	10843-001	10843-001															
10844	10844-001	10844-001	10844-001															
10845	10845-001	10845-001	10845-001															
10846	10846-001	10846-001	10846-001															
10847	10847-001	10847-001	10847-001															
10848	10848-001	10848-001	10848-001															
10849	10849-001	10849-001	10849-001															
10850	10850-001	10850-001	10850-001															
10851	10851-001	10851-001	10851-001															
10852	10852-001	10852-001	10852-001															
10853	10853-001	10853-001	10853-001															
10854	10854-001	10854-001	10854-001															
10855	10855-001	10855-001	10855-001															
10856	10856-001	10856-001	10856-001															
10857	10857-001	10857-001	10857-001															
10858	10858-001	10858-001	10858-001															
10859	10859-001	10859-001	10859-001															
10860	10860-001	10860-001	10860-001															
10861	10861-001	10861-001	10861-001															
10862	10862-001	10862-001	10862-001															
10863	10863-001	10863-001	10863-001															
10864	10864-001	10864-001	10864-001															
10865	10865-001	10865-001	10865-001															
10866	10866-001	10866-001	10866-001															
10867	10867-001	10867-001	10867-001															
10868	10868-001	10868-001	10868-001															
10869	10869-001	10869-001	10869-001															
10870	10870-001	10870-001	10870-001															
10871	10871-001	10871-001	10871-001															
10872	10872-001	10872-001	10872-001															
10873	10873-001	10873-001	10873-001															
10874	10874-001	10874-001	10874-001															
10875	10875-001	10875-001	10875-001															
10876	10876-001	10876-001	10876-001															
10877	10877-001	10877-001	10877-001															
10878	10878-001	10878-001	10878-001															
10879	10879-001	10879-001	10879-001															
10880	10880-001	10880-001	10880-001															
10881	10881-001	10881-001	10881-001															
10882	10882-001	10882-001	10882-001															

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Study #	Study Name	Study Design	Study Location	Study Period	Study Status	Study Results	Study Comments
10001	Study 1: Early Phase I	Phase I	US, Europe	1990-1995	Completed	100%	Successful
10002	Study 2: Phase II	Phase II	US, Europe	1995-2000	In Progress	85%	Good
10003	Study 3: Phase III	Phase III	US, Europe	2000-2005	Completed	90%	Excellent
10004	Study 4: Phase IV	Phase IV	US, Europe	2005-2010	In Progress	75%	Good
10005	Study 5: Phase V	Phase V	US, Europe	2010-2015	Completed	95%	Excellent
10006	Study 6: Phase VI	Phase VI	US, Europe	2015-2020	In Progress	60%	Good
10007	Study 7: Phase VII	Phase VII	US, Europe	2020-2025	Completed	80%	Good
10008	Study 8: Phase VIII	Phase VIII	US, Europe	2025-2030	In Progress	50%	Good
10009	Study 9: Phase IX	Phase IX	US, Europe	2030-2035	Completed	70%	Good
10010	Study 10: Phase X	Phase X	US, Europe	2035-2040	In Progress	40%	Good

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Pharmaceutical Products Research & Development
Grant System
SOSI PLAN Calling

Grant #	Project #	Project Name	Project Status	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total	Start	End
187571	N/A	PROSADIPALISA, TUMORIN	Completed	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Grand Total																	0.00	0.00

00718

Grant #	Project #	Project Name	Project Status	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total	Start	End
00718	N/A	PROSADIPALISA, TUMORIN	Completed	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Grand Total																	0.00	0.00

* When a new product is developed, the grant is a multiple, incremental to replace the grant awarded as well as the grant and not vice versa.
* This grant is awarded to the grantee, not the sponsor. The grant is awarded to the grantee, not the sponsor. The grant is awarded to the grantee, not the sponsor.
* This grant is awarded to the grantee, not the sponsor. The grant is awarded to the grantee, not the sponsor. The grant is awarded to the grantee, not the sponsor.

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ABBT 0037529

PPRD GREYBOOK
RECONCILIATIONS MONTH - \$
2001 PLAN

CONFIDENTIAL
DEPT AM

	GLOBAL														
CHARGES TO PROJECTS:	'01 PLAN	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	TOTAL	
Memo: Global Key Check		-	-	-	-	-	-	-	-	-	-	-	-		
Global	466,675	40,963	38,588	40,185	38,865	39,837	42,958	35,700	38,080	37,305	36,995	39,185	38,034	466,675	
Direct Service															
PPD Service	105,362	8,262	8,406	8,562	8,346	8,813	9,094	8,454	9,240	8,324	7,968	8,085	11,807	105,362	
Sister & Takada	57,348	5,113	5,113	5,113	5,113	5,113	5,113	5,113	5,113	5,113	5,113	5,113	1,105	57,348	
TOTAL GROSS EXPENSE	629,385	54,338	52,107	53,860	52,324	53,763	57,165	49,267	52,413	50,742	50,877	52,383	50,946	629,385	
LESS SISTER DIVISION CHARGES:															
AI Total	192,854	16,901	15,951	16,590	16,062	16,451	17,699	14,796	15,740	15,438	15,314	16,190	15,722	192,854	
TAP Pharm. Inc.	20,185	1,682	1,682	1,682	1,682	1,682	1,682	1,682	1,682	1,682	1,682	1,682	1,683	20,185	
HPD	8,634	736	736	736	736	736	736	736	736	736	736	736	738	8,634	
ADD	2,383	199	199	199	199	199	199	199	199	199	199	199	194	2,383	
SPD	4,909	409	409	409	409	409	409	409	409	409	409	409	410	4,909	
ROSS	1,955	163	163	163	163	163	163	163	163	163	163	163	162	1,955	
CPD	42	4	4	4	4	4	4	4	4	4	4	4	(2)	42	
CMIS	74	6	6	6	6	6	6	6	6	6	6	6	6	74	
Other Sister Division	16,772	1,398	1,398	1,398	1,398	1,398	1,398	1,398	1,398	1,398	1,398	1,398	1,394	16,772	
TOTAL CHARGES OUT	248,008	21,498	20,548	21,187	20,659	21,048	22,298	19,393	20,337	20,035	19,911	20,787	20,308	248,008	
PARO SERVICES SOLD IMPACT (Judgement)	3,890	333	333	333	333	333	333	332	332	332	332	332	332	3,890	
NET PPRD EXPENSE	385,367	33,173	31,892	33,006	31,998	33,048	35,202	30,285	32,408	31,039	30,498	31,928	30,969	385,367	
ACTUALS PER GREYBOOK (J:DRIVE)															
VARIANCE/KEY CHECK		(33,173)	(31,892)	(33,006)	(31,998)	(33,048)	(35,202)	(30,285)	(32,408)	(31,039)	(30,498)	(31,928)	(30,969)	(385,367)	
ACTUALS PER KIRNES/DAANA															
VARIANCE/KEY CHECK		(33,173)	(31,892)	(33,006)	(31,998)	(33,048)	(35,202)	(30,285)	(32,408)	(31,039)	(30,498)	(31,928)	(30,969)	(385,367)	
Memo: 2000 Actuals		32,133	30,404	35,911	33,138	32,058	45,704	28,013	27,124	29,386	27,095	27,115	27,512	375,593	
Memo:															
AI 2001 PLAN (12/08/00)		16,901	15,951	16,590	16,062	16,451	17,699	14,796	15,740	15,438	15,314	16,190	15,722	192,854	
AI Final 2000 AGU		10,645	14,364	14,799	14,474	16,424	17,281	17,969	15,360	19,401	19,301	15,441	15,581	192,040	
Net PPRD Expense	2001 PLAN Fav(Unfav) vs.														
	1Qtr	2Qtr	3Qtr	4Qtr	Total	1Qtr	2Qtr	3Qtr	4Qtr	Total					
2001 PLAN (12/08/00)	98,071	100,248	93,653	93,795	385,367										
% of total	25.4%	26.0%	24.3%	24.2%	99.9%										
2000 Final AGU	98,448	110,900	84,906	80,476	374,730	377	10,652	(8,747)	(12,919)	(10,637)					
% of total	26.3%	29.6%	22.7%	21.5%	100.1%	0.4%	9.8%	-10.3%	-16.1%	-2.8%					
2000 Actuals	98,448	110,900	84,523	81,722	375,593	377	10,652	(9,130)	(11,673)	(8,774)					
% of total	26.2%	29.5%	22.5%	21.8%	100.0%	0.4%	9.8%	-10.8%	-14.3%	-2.6%					

LC:GROUP PLANNING/2001 PLAN/2001 FINAL Dec01/1994

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ABBT 0037530

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PPRD GREYBOOK
RECONCILIATIONS YTD - \$
2001 PLAN

02/28/01
09:57 AM

	GLOBAL												
CHARGES TO PROJECTS:	'01 PLAN	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC
Global	466,675	40,963	79,551	118,736	158,801	198,438	241,296	277,096	315,156	352,461	389,456	428,641	466,675
Direct Service													
PPD Service	105,362	8,262	16,888	25,230	33,576	42,389	51,483	59,837	68,177	77,501	85,470	93,555	105,362
Sister & Takeda	57,348	5,113	10,226	15,339	20,452	25,565	30,678	35,791	40,804	46,017	51,130	56,243	57,348
TOTAL GROSS EXPENSE	629,385	54,338	106,445	160,305	212,629	266,392	323,557	372,624	425,237	475,978	528,056	578,439	629,385
LESS SISTER DIVISION CHARGES:													
AI Total	192,854	16,901	32,852	49,442	65,504	81,955	99,854	114,450	130,190	145,828	160,942	177,132	192,854
TAP Pharm, Inc.	20,185	1,682	3,364	5,046	6,728	8,410	10,092	11,774	13,456	15,138	16,820	18,502	20,185
HPD	8,834	736	1,472	2,208	2,944	3,680	4,416	5,152	5,888	6,624	7,360	8,096	8,834
ADD	2,383	199	398	597	796	995	1,194	1,393	1,592	1,791	1,990	2,189	2,383
SPD	4,909	408	818	1,227	1,636	2,045	2,454	2,863	3,272	3,681	4,090	4,499	4,909
ROSS	1,955	163	326	489	652	815	978	1,141	1,304	1,467	1,630	1,793	1,955
CPD	42	4	8	12	16	20	24	28	32	36	40	44	42
CMIS	74	6	12	18	24	30	36	42	48	54	60	66	74
Other Sister Division	16,772	1,398	2,796	4,194	5,592	6,990	8,388	9,786	11,184	12,582	13,980	15,378	16,772
TOTAL CHARGES OUT	248,008	21,498	42,046	63,233	83,882	104,940	127,236	148,629	166,966	187,001	206,912	227,699	248,008
PARD SERVICES SOLD IMPACT (Judgement)	3,990	333	666	999	1,332	1,665	1,998	2,330	2,662	2,994	3,326	3,658	3,990
NET PPRD EXPENSE	385,367	33,173	65,065	98,071	130,069	163,117	198,319	228,525	260,933	291,972	322,470	354,398	385,367

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PPD RESEARCH AND DEVELOPMENT 2001 PLAN P&L BY CALENDARIZATION													EXPENSE BEST AN
Modeling Factor: Input # months actuals in cell below	1	2	3	4	5	6	7	8	9	10	11	12	
Modeling Calculations are in italics & pink light	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	TOTAL
Modeling Factor: Input total Global \$'s in cell D													
488,675													
Global:													
Discovery Deals	0	625	2,015	250	625	2,015	250	625	2,015	250	625	3,151	12,446
General Payments	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0	0
Global Grants	7,511	8,200	8,786	9,136	9,306	10,186	8,604	9,010	8,788	5,794	8,773	9,654	104,748
Global SPD	3,923	3,923	3,923	3,923	3,923	3,923	3,923	3,923	3,923	3,923	3,923	3,915	47,069
Subtotal - Identified Global Expenses	11,434	12,748	14,724	13,309	13,854	16,124	12,777	13,558	14,726	9,967	14,321	15,721	184,263
All Other (see allocation basis at Memo 1)	28,321	26,804	25,267	25,086	25,904	26,801	23,655	24,836	23,141	26,028	24,689	21,880	302,412
Total Global as Calculated	39,755	39,552	39,991	38,395	39,758	42,925	36,332	38,394	37,867	35,995	39,010	38,701	486,675
Adjust to Frozen AI Sellout	1,208	(854)	194	470	79	33	(632)	(304)	(562)	1,000	175	(657)	0
Total Global as Calculated	40,963	38,698	40,185	38,865	39,837	42,958	35,700	38,090	37,305	36,995	39,185	38,044	486,675
Less AI Shares	(16,385)	(15,435)	(16,074)	(15,546)	(15,935)	(17,183)	(14,280)	(15,224)	(14,922)	(14,798)	(15,674)	(15,214)	(166,670)
Domestic:													
Domestic Grants	762	32	1,319	1,320	1,320	1,320	1,200	1,801	1,228	993	993	992	(104,748)
Domestic SPD	531	531	531	531	531	531	531	531	531	531	531	525	6,366
Subtotal - Identified Domestic Expenses	1,293	563	1,850	1,851	1,851	1,731	2,332	1,759	1,524	1,524	1,524	1,517	(98,382)
All Other	7,302	8,176	7,045	6,828	7,285	7,576	7,655	7,240	6,897	6,777	6,893	6,532	85,716
Total Domestic	8,595	8,739	8,895	8,679	9,136	9,427	8,786	9,572	8,656	8,301	8,417	8,149	105,262
Memo 1:													
Total Net PPD R&D Expense	33,173	31,892	33,006	31,998	33,048	35,202	30,206	32,408	31,039	30,498	31,928	30,969	385,367
Less 100% of Identified Domestic Exp (above)	(1,293)	(563)	(1,850)	(1,851)	(1,851)	(1,731)	(2,332)	(1,759)	(1,524)	(1,524)	(1,517)	(1,517)	(19,846)
Less 50% of Identified Global Exp (above)	(8,860)	(7,643)	(8,834)	(7,985)	(8,312)	(9,874)	(7,666)	(8,135)	(8,836)	(5,980)	(8,593)	(10,003)	(98,557)
All Other Not yet Calendarized (Allocation base)	25,020	23,680	22,322	22,182	22,985	23,677	20,809	21,941	20,444	22,984	21,911	19,418	257,163
Calculations preliminary calendarizations for TDR review packages													
1) Input actuals to detailed model. Confirm that net R&D line in J drive (P&L/P&LCA/ WK4).													
2) Input items pulling into "Identified Global Expenses" and "Identified Domestic Expenses" above													
- From analytic: Discovery New Technology, Grants, SPD, License payments, refunds, etc.													
- We can guessimate Discovery functions													
3) Input modeling factors above (# months actuals and total global \$'s)													
4) Make sure calendarization sheets (column B in Global Grants, Func Expense, Svcs Purchased, Svcs Sold) are pulling correct annual # from Op Cost Stmt													
5) Model Quarterly Profile													
6) Model net R&D calendarization below. (Inputs are in blue.) Plug all other to achieve qtrly profile													
7) For APD preliminary estimates, March = Flash, April = Plan + Blue Plan impact													
For AGU preliminary estimates, July = Flash (if not available, use APU + BPI), August = APU + Blue Plan impact													
8) Input Net R&D (as calculated below) to Func Expense Net Income sheet Line 87, on "This is input, judgment plugs to this \$" line.													
Identified Global Expenses (Net)	6,860	7,649	8,834	7,985	8,312	9,674	7,666	8,135	8,836	5,980	8,593	10,003	98,557
Identified Domestic Expenses	1,293	563	1,850	1,851	1,851	1,731	2,332	1,759	1,524	1,524	1,517	1,517	19,846
Payroll	0	200	400	600	800	1,000	1,200	1,400	1,600	1,800	2,000	2,200	13,200
Adjustment for PLAN	0	0	0	0	0	0	0	0	0	0	0	0	0
TBD	0	0	0	0	0	0	0	0	0	0	0	0	0
TBD	0	0	0	0	0	0	0	0	0	0	0	0	0
Subtotal - Identified Net Expenses	8,153	8,412	11,084	10,436	10,963	12,525	10,597	11,667	12,195	8,304	12,117	13,750	131,403
All Other - see (a) for Actuals	25,020	23,480	21,822	21,562	22,085	22,677	19,609	20,541	18,844	21,194	19,811	17,218	253,964
Net R&D	33,173	31,892	33,006	31,998	33,048	35,202	30,206	32,408	31,039	30,498	31,928	30,969	385,367
Current Calendarization													
2000 Final AGU	32,133	30,404	35,911	33,138	32,058	45,704	28,013	27,124	29,768	26,703	27,355	26,418	374,730
2000 Actuals	32,133	30,404	35,911	33,138	32,058	45,704	28,013	27,124	29,768	26,703	27,355	26,418	374,730
2001 Quarterly Profile	1Qtr	2Qtr	3Qtr	4Qtr	Total								
2001 PLAN (12/08/00)	98,071	100,248	93,653	93,395	385,367								
Blue Plan	0	0	0	0	0								
Changes:	0	0	0	0	0								
TBD	0	0	0	0	0								
TBD	0	0	0	0	0								
Other (DIP)	0	0	0	0	0								
Total Expected PLAN	98,071	100,248	93,653	93,395	385,367								
Expected PLAN	0	0	0	0	0								

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PHARMACEUTICAL PRODUCTS RESEARCH & DEVELOPMENT
2001 PLAN
GLOBAL AI CALENDARIZATION

02/18/01
02:07 AM

	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	TOTAL
Global AI	16,385	15,435	16,074	15,546	15,935	17,183	14,280	15,224	14,922	14,798	15,674	15,214	186,570
Total Fixed AI	199	199	199	199	199	199	199	199	199	199	199	195	2,384
Total Direct AI	317	317	317	317	317	317	317	317	317	317	317	313	3,800
Total AI Support	516	516	516	516	516	516	516	516	516	516	516	508	6,184
Total Global	16,901	15,851	16,590	16,062	16,451	17,699	14,796	15,740	15,438	15,314	16,190	15,722	192,854
2000 AGU Global AI	10,645	14,364	14,789	14,474	16,424	17,281	17,989	15,360	19,401	19,301	16,441	15,581	192,040

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PPRD SERVICES PURCHASED - SPD
RECONCILIATIONS YTD - \$
2001 PLAN

02/19/01
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TOTAL FIXED AND DIRECT CHARGES	'01 PLAN	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	TOTAL
PASS THROUGH CHARGES:														
Protease 2nd Gen (ABT 378)														
Macrolide (ABT 773)	14,970	1,248	2,496	3,744	4,992	6,240	7,488	8,736	9,984	11,232	12,480	13,728	14,970	14,970
Macrolide (ABT 773) Pediatric														
Macrolide (ABT 773) LV														
Cholinergic Channel Modulator														
BPH Backup														
Endothelin	683	57	114	171	228	285	342	399	456	513	570	627	683	683
NPS-1776	490	41	82	123	164	205	246	287	328	369	410	451	490	490
Quinolone	5,762	480	960	1,440	1,920	2,400	2,880	3,360	3,840	4,320	4,800	5,280	5,762	5,762
Cancer - Anti Mitotic (Eisai-7010)	1,172	98	196	294	392	490	588	686	784	882	980	1,078	1,172	1,172
Clari 140H														
Cancer - Angiogenesis	2,753	229	458	687	916	1,145	1,374	1,603	1,832	2,061	2,290	2,519	2,753	2,753
Clari IV	4,297	358	716	1,074	1,432	1,790	2,148	2,506	2,864	3,222	3,580	3,938	4,297	4,297
Clari Process Improvements	1,700	142	284	426	568	710	852	994	1,136	1,278	1,420	1,562	1,700	1,700
New Products														
Misc Process Impv (ery Danisco)														
Subtotal Pass Through	31,627	2,653	5,306	7,959	10,612	13,265	15,918	18,571	21,224	23,877	26,530	29,183	31,627	31,627
DISCOVERY														
Natural Products Discovery														
Patents & Trademarks	370	31	62	93	124	155	186	217	248	279	310	341	370	370
Miscellaneous (Depr adjusted here)														
Discovery Special Labs	2,621	218	436	654	872	1,090	1,308	1,526	1,744	1,962	2,180	2,398	2,621	2,621
Subtotal Discovery	2,991	249	498	747	996	1,245	1,494	1,743	1,992	2,241	2,490	2,739	2,991	2,991
OTHER														
Dom Other-Ery Proc Imp	369	31	62	93	124	155	186	217	248	279	310	341	369	369
Global Other - Clari I														
Global Other - Clari IV														
Global Other - ABT 378 IV														
Global Other - Misc PMP														
Global Other - Misc (Add'l Warehou	23	2	4	6	8	10	12	14	16	18	20	22	23	23
Protease 2nd Gen to PPNC														
New Projects	5,390	449	898	1,347	1,796	2,245	2,694	3,143	3,592	4,041	4,490	4,939	5,390	5,390
New Projects	1,225	102	204	306	408	510	612	714	816	918	1,020	1,122	1,225	1,225
Excess Capacity	11,610	968	1,936	2,904	3,872	4,840	5,808	6,776	7,744	8,712	9,680	10,648	11,610	11,610
Unit of Activity Charges														
Global Other-Misc. MUH Adjust														
Total SPD	53,435	4,454	8,908	13,362	17,816	22,270	26,724	31,178	35,632	40,086	44,540	48,994	53,435	53,435

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PPRD SERVICES PURCHASED - SPD
RECONCILIATIONS MONTH - 3
2001 PLAN

NOTES

FIXED CHARGES	71 PLAN	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	TOTAL
PASS THROUGH CHARGES														
Protease 2nd Gen (AST 378)	--	--	--	--	--	--	--	--	--	--	--	--	--	--
Macrolide (AST 773)	5,562	464	464	464	464	464	464	464	464	464	464	464	458	5,562
Macrolide (AST 773) Pediatric	--	--	--	--	--	--	--	--	--	--	--	--	--	--
Macrolide (AST 773) LV	--	--	--	--	--	--	--	--	--	--	--	--	--	--
Cholinergic Channel Modulator	--	--	--	--	--	--	--	--	--	--	--	--	--	--
BPH Backup	--	--	--	--	--	--	--	--	--	--	--	--	--	--
Endothelin	490	41	41	41	41	41	41	41	41	41	41	41	39	490
APC-1776	490	41	41	41	41	41	41	41	41	41	41	41	39	490
Quinone	3,362	280	280	280	280	280	280	280	280	280	280	280	282	3,362
Cancer - Anti Mitotic (Easi-7010)	907	76	76	76	76	76	76	76	76	76	76	76	71	907
Clari 140H	--	--	--	--	--	--	--	--	--	--	--	--	--	--
Cancer - Angiogenesis	2,085	174	174	174	174	174	174	174	174	174	174	174	171	2,085
Clari IV	1,225	102	102	102	102	102	102	102	102	102	102	102	100	1,225
Clari Process Improvements	748	62	62	62	62	62	62	62	62	62	62	62	66	748
New Products	--	--	--	--	--	--	--	--	--	--	--	--	--	--
Most Process Inexp (any Danisco)	--	--	--	--	--	--	--	--	--	--	--	--	--	--
Subtotal Pass Through	14,863	1,240	1,240	1,240	1,240	1,240	1,240	1,240	1,240	1,240	1,240	1,240	1,228	14,869
DISCOVERY														
Natural Products Discovery	--	--	--	--	--	--	--	--	--	--	--	--	--	--
Patents & Trademarks	--	--	--	--	--	--	--	--	--	--	--	--	--	--
Macrolactone (Deep adjusted here)	--	--	--	--	--	--	--	--	--	--	--	--	--	--
Discovery Special Labs	2,621	218	218	218	218	218	218	218	218	218	218	218	223	2,621
Subtotal Discovery	2,621	218	218	218	218	218	218	218	218	218	218	218	223	2,621
OTHER														
Dom Other-Ery Proc Imp	389	31	31	31	31	31	31	31	31	31	31	31	28	389
Global Other - Clari I	--	--	--	--	--	--	--	--	--	--	--	--	--	--
Global Other - Clari IV	--	--	--	--	--	--	--	--	--	--	--	--	--	--
Global Other - AST 378 IV	--	--	--	--	--	--	--	--	--	--	--	--	--	--
Global Other - Misc PMP	--	--	--	--	--	--	--	--	--	--	--	--	--	--
Global Other - Misc Adg't Warehouse	23	2	2	2	2	2	2	2	2	2	2	2	1	23
Protease 2nd Gen to PPNC	--	--	--	--	--	--	--	--	--	--	--	--	--	--
New Projects	5,390	449	449	448	448	448	448	448	449	448	448	448	451	5,390
New Projects	1,225	102	102	102	102	102	102	102	102	102	102	102	103	1,225
Genass Capacity	11,610	968	968	968	968	968	968	968	968	968	968	968	962	11,610
Unit of Activity Charges	--	--	--	--	--	--	--	--	--	--	--	--	--	--
Global Other-Misc. MUR Adjust	--	--	--	--	--	--	--	--	--	--	--	--	--	--
Total SPD Fixed Charges	35,197	3,010	3,010	3,010	3,010	3,010	3,010	3,010	3,010	3,010	3,010	3,010	2,997	35,197

[illegible]

LYNCH, P. L. AND C. D. PLANT. 1981. PLANT COMMUNITY DEVELOPMENT IN A TROPICAL RAIN FOREST.

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PPRD SERVICES PURCHASED - SPD
RECONCILIATIONS YTD - 3
2001 PLAN

	Y1 PLAN	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	TOTAL
FIXED CHARGES														
PASS THROUGH CHARGES:														
Prostate 2nd Gen (ABT 370)														
Macrolide (ABT 773)	5,562	464	828	1,392	1,856	2,320	2,784	3,248	3,712	4,176	4,640	5,104	5,568	5,562
Macrolide (ABT 773) Pediatric														
Macrolide (ABT 773) I.V.														
Cholinergic Channel Modulator														
BPH Backup														
Endoscopy	490	41	82	123	164	205	246	287	328	368	410	451	490	490
NPS-1778	490	41	82	123	164	205	246	287	328	369	410	451	490	490
Quinolone	3,362	280	560	840	1,120	1,400	1,680	1,960	2,240	2,520	2,800	3,080	3,362	3,362
Cancer - Anti Mitotic (Ebsai-7010)	907	76	152	228	304	380	456	532	608	684	760	836	907	907
Clari 140H														
Cancer - Angiogenesis	2,085	174	348	522	696	870	1,044	1,218	1,392	1,566	1,740	1,914	2,085	2,085
Clari IV	1,225	102	102	102	102	102	102	102	102	102	102	102	205	205
Clari Prostatis Improvements	748	62	62	62	62	62	62	62	62	62	62	62	185	185
New Products	748	62	124	196	248	310	372	434	496	558	620	682	748	748
Minor Process Improv (new Danisco)														
Subtotal Pass Through	15,871	1,302	2,440	3,578	4,716	5,854	6,992	8,130	9,268	10,406	11,544	12,682	14,014	14,014

DISCOVERY

DISCOUNT											
Natural Products Discovery	-	-	-	-	-	-	-	-	-	-	-
Patents & Trademarks	-	-	-	-	-	-	-	-	-	-	-
Miscellaneous (Dep't adjusted here)	-	-	-	-	-	-	-	-	-	-	-
Discovery Special Labs	2,621	218	438	654	872	1,050	1,308	1,528	1,744	1,962	2,180
Subtotal Discovery	2,621	218	438	654	872	1,050	1,308	1,528	1,744	1,962	2,180

OTHER:

Drop Other-Ery Proc Imp	369	31	62	93	124	155	188	217	248	278	310	341	369	369
Global Other - Class I	--	--	--	--	--	--	--	--	--	--	--	--	--	--
Global Other - Class IV	--	--	--	--	--	--	--	--	--	--	--	--	--	--
Global Other - ABT 378 IV	--	--	--	--	--	--	--	--	--	--	--	--	--	--
Global Other - Mac PMP	--	--	--	--	--	--	--	--	--	--	--	--	--	--
Global Other - Mac, Acct Warehouse	23	2	4	--	--	18	12	18	18	18	20	22	23	23
Protease 2nd Gen to PPMC	--	--	--	--	--	--	--	--	--	--	--	--	--	--
New Projects	5,390	449	858	1,347	1,796	2,245	2,894	3,143	3,562	4,041	4,430	4,928	5,390	5,390
New Projects	1,225	162	204	308	408	510	612	714	818	918	1,020	1,122	1,225	1,225
Excess Capacity	11,810	868	1,938	2,904	3,872	4,840	5,808	6,776	7,744	8,712	9,680	10,648	11,610	11,610
Unit of Activity Charges	--	--	--	--	--	--	--	--	--	--	--	--	--	--
Global Other-Misc. MJN Adjust	--	--	--	--	--	--	--	--	--	--	--	--	--	--
Total SPD Rised Charges	25,856	3,072	5,990	8,883	11,776	14,764	17,812	20,520	23,478	26,236	29,244	32,152	35,252	35,252

DIRECT CHARGES

PASS THROUGH CHARGES																											
Protease 2nd Gen (ABT 378)	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--
Macrolide (ABT 772)	9,408	784	1,568	2,352	3,136	3,920	4,704	5,488	6,272	7,056	7,840	8,624	9,408	9,408													
Macrolide (ABT 773) Pediatric	--	--	--	--	--	--	--	--	--	--	--	--	--	--													
Macrolide (ABT 773) I.V.	--	--	--	--	--	--	--	--	--	--	--	--	--	--													
Cholinergic Channel Modulator	--	--	--	--	--	--	--	--	--	--	--	--	--	--													
BPH Backup	--	--	--	--	--	--	--	--	--	--	--	--	--	--													
Endothelin	193	16	32	48	64	80	96	112	128	144	160	176	193	193													
NPS-1776	--	--	--	--	--	--	--	--	--	--	--	--	--	--													
Quinolone	2,400	200	400	600	800	1,000	1,200	1,400	1,600	1,800	2,000	2,200	2,400	2,400													
Cancer - Anti Mitotic (Etsal-7010)	205	22	44	66	88	110	132	154	176	198	220	242	265	265													
Clas 140H	--	--	--	--	--	--	--	--	--	--	--	--	--	--													
Cancer - Angiogenesis	668	55	110	165	220	275	330	385	440	495	550	605	668	668													
Clas IV	3,072	250	512	768	1,024	1,280	1,536	1,792	2,048	2,304	2,560	2,816	3,072	3,072													
Chem Process Improvements	852	80	160	240	320	400	480	560	640	720	800	880	962	962													
New Products	--	--	--	--	--	--	--	--	--	--	--	--	--	--													
Misc. Process Impr. (per Damage)	--	--	--	--	--	--	--	--	--	--	--	--	--	--													
Subtotal Pass Through	16,950	1,413	2,826	4,239	5,652	7,065	8,478	9,891	11,304	12,717	14,130	15,543	16,950	16,950													

DISCOVERY

Natural Products Discovery	---	---	---	---	---	---	---	---	---	---	---	---
Patents & Trademarks	370	31	62	93	124	155	186	217	248	279	310	341
Miscellaneous (Depr adjusted here)	---	---	---	---	---	---	---	---	---	---	---	---
Discovery Special Labs	---	---	---	---	---	---	---	---	---	---	---	---
Subtotal Discovery	370	31	62	93	124	155	186	217	248	279	310	341

OTHER

Dorm Other-Ery Proc Imp																			
Global Other - Clair I																			
Global Other - Clair IV																			
Global Other - ABT 378 IV																			
Global Other - Misc PMP																			
Global Other - Misc Addtl Warehouse																			
Pretaxess 2nd Gen to PPNC																			
New Projects																			
New Projects																			
Excess Capacity																			
Unit of Activity Charges																			
Global Other-Misc MJM Adjust																			
Total SPD Direct Charges	17,329	1,444	2,888	4,332	5,776	7,220	8,664	10,108	11,552	12,996	14,440	15,884	17,328	17,328					

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PPRD SERVICES PURCHASED - SPD
RECONCILIATIONS MONTH - \$
2001 PLAN

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	'01 PLAN	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	TOTAL
SUMMARY SPD														
Total Pilot Plant/PMP Stack Card	24,497	2,042	2,042	2,042	2,042	2,042	2,042	2,042	2,042	2,042	2,042	2,042	2,035	24,497
Total Bulk Drug Direct	17,328	1,444	1,444	1,444	1,444	1,444	1,444	1,444	1,444	1,444	1,444	1,444	1,444	17,328
Total Excess Capacity Stack Card	11,610	968	968	968	968	968	968	968	968	968	968	968	962	11,610
Total SPD	53,435	4,454	4,454	4,454	4,454	4,454	4,454	4,454	4,454	4,454	4,454	4,454	4,441	53,435
SUMMARY GLOBAL/DOMESTIC														
Total Global SPD	47,069	3,923	3,923	3,923	3,923	3,923	3,923	3,923	3,923	3,923	3,923	3,923	3,916	47,069
Total All Other Domestic SPD	6,366	531	531	531	531	531	531	531	531	531	531	531	525	6,366
Total SPD	53,435	4,454	4,454	4,454	4,454	4,454	4,454	4,454	4,454	4,454	4,454	4,454	4,441	53,435

KEY CHECK (S/B 0) ->

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PPRD SERVICES PURCHASED - SPD
RECONCILIATIONS YTD - \$
2001 PLAN

	'01 PLAN	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	TOTAL
SUMMARY SPD														
Total Pilot Plant/PMP Stack Card	24,497	2,042	4,084	6,126	8,168	10,210	12,252	14,294	16,336	18,378	20,420	22,462	24,497	24,497
Total Bulk Drug Direct	17,328	1,444	2,888	4,332	5,776	7,220	8,664	10,108	11,552	12,996	14,440	15,884	17,328	17,328
Total Excess Capacity Stack Card	11,610	968	1,936	2,904	3,872	4,840	5,808	6,776	7,744	8,712	9,680	10,648	11,610	11,610
Total SPD	53,435	4,454	8,908	13,362	17,816	22,270	26,724	31,178	35,632	40,086	44,540	48,994	53,435	53,435
SUMMARY GLOBAL/DOMESTIC														
Total Global SPD	47,069	3,923	7,846	11,769	15,692	19,615	23,538	27,461	31,384	35,307	39,230	43,153	47,069	47,069
Total All Other Domestic SPD	6,366	531	1,062	1,593	2,124	2,655	3,186	3,717	4,248	4,779	5,310	5,841	6,366	6,366
Total SPD	53,435	4,454	8,908	13,362	17,816	22,270	26,724	31,178	35,632	40,086	44,540	48,994	53,435	53,435

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PPRD AFFORDABILITY
RECONCILIATIONS MONTH - \$
2001 PLAN

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	2001 PLAN	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	TOTAL
SDG/Other	---	---	---	---	---	---	---	---	---	---	---	---	---	---
HIV/Knot/QD/Other	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Aegis Insurance	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Genset #1	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Genset #2	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Neurosearch FTE \$2530, depr \$200	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Coactivon	---	---	---	---	---	---	---	---	---	---	---	---	---	---
SPD IDV Liponavir	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Thrombolytics to HPD (Ovrhd & Grants)	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Data Management Absorption	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Other New Products	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Quinolone Payment	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Division Task	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Total SDG/Other	---	---	---	---	---	---	---	---	---	---	---	---	---	---

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Key Issues in 2001

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Figure

**Pharmaceutical Research & Development
Key Plus/Minus List
2001
(\$MM's)**

Description	Commentary	Probability	Fav/(Unfav)
DPI Agreement	Licensing agreement with Discovery Partners International. Accounting to be clarified with Corporate.	High	2.0
SPD Bulk drug for Ketolide	Discussions are currently on-going with SPD to drop the number of bulk manufacturing campaign runs from 6 to 4 for the April Update.	High	1.5 - 2.0
Kelitra FDA Strategy	The current Kelitra budget assumes all data that is scheduled to be submitted as part of the FDA Accelerated Approval Unstable will be sufficient. In the event that the data is inconclusive (as determined by the FDA) additional dollars will be needed to continue existing studies.	High	(1.2)
Subtotal for High Probability Scenarios			2.3 - 2.8
CCM Milestone Funding	Go/No go decision is scheduled for May/June 2001. If the decision to continue development is made, additional funding will be needed to continue the program.	Medium	(0.8)
Ketolide Japan	Japan Phase I/II studies have been milestones funded. If positive data is available in the 4Q (this is the projected start date of the study), funding will be needed to stay on target with the expectations of Japan regulators.	Medium	(4.0)
Quinolone Milestones Payment	Currently, Phase IIB milestone payment is unfunded. If current enrollment levels are achieved for Phase IIB, additional funding will be necessary to satisfy our contractual obligations. There is a high probability that the contract will be re-negotiated and the milestone payment will then come due in 1Q 2002.	Medium	(3.5)
Subtotal for Medium Probability Scenarios			(17.3)
Immunosuppressant Sale	Sale of this compound is expected in 2001. Global Pharmaceutical R&D Division could potentially receive the revenue from this sale.	Low	6.0
Karo Bio DDC	If Karo Bio does not produce a DDC, we will not owe them a milestone payment in 2001.	Low	1.0
Bimacromol Funding	Go/No go decision is expected in late 1Q or early 2Q 2001. If the decision to continue development is made, Phase III studies will require funding.	Low	(11.7)
Subtotal for Low Probability Scenarios			(8.7)

LOB/OP/Finance/PRT/Reg Affairs (Karl Johnson)
2/20/01

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2001 PLAN
PHARMACEUTICAL PRODUCTS RESEARCH & DEVELOPMENT

	In	Out
NEUROLOGY		
Depakote	<ul style="list-style-type: none"> - On going activities: steady agitation, impulsive aggression, psychosis - New activities: polycystic ovary, new DR form, 250mg ER definitive bio 	<ul style="list-style-type: none"> - New formulations: epilepsy & migraine - Bipolar in pediatric market - Dose Proportionality - Pediatric Pseud Extension - Psych - Acute Migraine - Depakote Status Epilepticus
ABT-594	<ul style="list-style-type: none"> - Milestone funded to Go/No Go decision June 2001 for neuropathic pain 	<ul style="list-style-type: none"> - Funding for 3rd and 4th qtr R Go - Phase IIB Chronic Persistent Pain
COX- II	<ul style="list-style-type: none"> - Completion of work started in 2000 bringing it to a logical stopping point 	<ul style="list-style-type: none"> - Continuation of pre clinical and Phase I studies
ABT-018	<ul style="list-style-type: none"> - Completion of work started in 2000 bringing it to a logical stopping point 	<ul style="list-style-type: none"> - Single/Multiple rising dose Ph I study
ABT-103	<ul style="list-style-type: none"> - Completion of work started in 2000 bringing it to a logical stopping point 	<ul style="list-style-type: none"> - Pre clinical studies - Single rising dose Ph I study
NPS-1776	<ul style="list-style-type: none"> - Completion of work started in 2000 bringing it to a logical stopping point 	<ul style="list-style-type: none"> - Pre clinical studies - Single and rising multiple dose Ph I study and formulation bio studies
Hydrocodone/buprenorphine	<ul style="list-style-type: none"> - Rapid dissolve and controlled release forms 	
ANTI-INFECTION		
Clarithromycin	<ul style="list-style-type: none"> - Extended Release Once/Day - Phase IV Int 	<ul style="list-style-type: none"> - Cystic Fibrosis - Asthma
Keoxide	<ul style="list-style-type: none"> - Tablet FDA delayed review forcing ABT to add new sites and redo efficacy studies to maintain NDA filing date. Cost = \$5.6MM - Drug Interaction studies: Warfarin, Digoxin & Gerdaxio #17 	<ul style="list-style-type: none"> - IV - Pediatric - Japan Ph I/II - Drug Interaction studies: Lorazepam, Carbamazepine & Cyclosporine
Quinolone	<ul style="list-style-type: none"> - Tablet - \$3MM milestones payment for initiating Ph I/A 	<ul style="list-style-type: none"> - Milestone payment for initiation of Ph IIB \$3.6MM
Neuraminidase (ABT-077)		<ul style="list-style-type: none"> - 2 week technology study - single rising dose study - multiple rising dose study
Onitesol	<ul style="list-style-type: none"> - Oritis Media 	<ul style="list-style-type: none"> - AECB & Phenytoin

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UROLOGY/CARDIOLOGY**Renaltriate (Fournier)**

In	Out
- Medical Affairs / Ph IV base level support	- Diabetes - PH Women - Fero Post MI

KCO

- Pre Clinicals

HIV**Ritonavir**

- Novartis / Roche Combo
- Efficacy A & B

Kaletra

- IBHSC/Auralex
- Kofit (BSC reinitiation)
- HAART Metabolic complications
- Start Phase IIIa Switch & Survival
- Expanded Access
- Ph II Pediatric
- Ph III Nerve

- Current assumption is that long term safety data from completed portion of Ph II Pediatric and Ph III Nerve studies will suffice for FDA requirements. If the FDA requires us to finish those studies we will need about \$1.2MM.

Cyclosporine

- PREP
- European Switch Kidney plus Extension
- Pediatric PK

CANCER**Endothelin (ABT-627)**

- Ph III pivotal study #1
- Initiate Ph III pivotal study #2
- QTO
- Bioequivalence
- Drug Interaction studies: Pexofenadine

- Early Stage Pcs
- Ph II exploratory
- Drug Interaction studies: Midazolam, Ketorolac & Riluzole

TSP #1 (ABT-610)

- Multiple dose in cancer patients
- IND study

- Manufacturing & Toxicology

Metoprolol

- Multiple dose in cancer patients
- IND study

- Manufacturing & Toxicology

Anti-Mitotic (ABT-724)

- Multiple dose in cancer patients
- IND study

K-6

- Pre clinical / Ph I studies

FTI #2

- Pre clinical / Ph I studies

Other New Products

- DDC's & In - licensing

Other

- ADF, Exploratory, AEGIS Meds, productivity projects
- Biomedicine

Discovery

- Genet

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Analgesia Venture
ABT-089
2001 PLAN KEY STATISTICS Pass II
(\$000)

<u>Project</u>	<u>2001</u>	<u>2000</u>	<u>2001</u>	<u>Target vs PLAN</u>
	<u>Target</u>	<u>AGU</u>	<u>PLAN</u>	<u>Fer(Unfnd) Var</u>
Neuronal nicotinic receptor modulator (Unfunded)	600	3,000	613	(13)

<u>Key Milestones / Assumptions</u>	<u>00 AGU</u>	<u>01 PLAN</u>	<u>Status (on target, pending or delayed to)</u>
- Translation Team Go/No Go		TBD	Unfunded, program on hold
-			
-			
-			
-			

<u>PARD</u>	<u>00 AGU</u>	<u>01 PLAN</u>
- Analytics Dev & Support	136	
- Formulation Dev & Support	147	
- Clinical Finishing	34	
- Project Management Support	29	
- PARD Total	366	

<u>Total Venture Management</u>	<u>SPU Requirements</u>
- Expense: \$3,986, reflecting milestone funding	<u>Kip</u> <u>Hand</u> <u>Mnt Cost</u> <u>Total Cost</u>
- Authorized Heads: Flat to AGU until July, 2001, ABT-594, Go/No Go Decision, then 11 headcount after July, 2001	2000 AGU 2001 PLAN 2000 AGU 01 PLAN 2001 PLAN

<u>Clinical Grants</u>	<u>1st Patient</u>	<u>Last</u>	<u>R/oss</u>	<u>2000 AGU</u>	<u>2001 PLAN</u>	<u>Cost</u>
	<u>Dosed</u>	<u>CRF</u>		<u>Start</u>	<u>End</u>	<u>00 AGU</u> <u>01 PLAN</u> <u>Variance</u>
<u>Phase I</u>						

Total

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Analgesia Venture
NPS 1776
2001 PLAN KEY STATISTICS Page II
(\$000)

Project	2001		2000		2001		Target vs PLAN Fav(Unfav) Var
	Target	AGU	PLAN	AGU	PLAN		
NPS-1776 (Unfunded)	500	537	(37)	

Key Milestones / Assumptions		80 AGU	01 PLAN	4/2001	Status (on target, pending or delayed to 2)
DDC Meeting					

PARD		80 AGU	01 PLAN
<ul style="list-style-type: none"> Analytes Dev & Support Formulation Dev & Support Clinical Finishing Project Management Support PARD Total 			

Total Venture Management		SPD Requirements	
<ul style="list-style-type: none"> Expense: \$3,988, reflecting milestone funding Authorized Heads: Flat to AGU until July, 2001, ABT-394, Or/No Go Decision, then 11 headcount after July, 2001 		Kgr	Total Cost
		2000 AGU	...
		2001 PLAN	490

Clinical Grants		R/loss		Cost	
Let Patient	Last	2000 AGU	2001 PLAN	00 AGU	01 PLAN
Dosed	CRF	Start	End	Total	Variance

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Total
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**ANTI-INFECTION FRANCHISE
CLARITHROMYCIN
2001 PLAN KEY STATISTICS
(\$000)**

Indication	2000 AGU	2001 Plan	2001 PLAN Fav(Unif) vs. AGU
Extended Release Once/Day	10,688	3,485	6,223
Pediatric New Strength (M-C)	107	41	66
XL AMR Patent Protection world wide (PARD/DOC)	883	162	731
AI Pediatric	4,573	30	4,543
Phase IV Ind	3,091	9,395	(6,304)
AI 1 Gram Tablet	2,985	11	2,974
Japan 400MG Tablet	1,881	0	1,881
Other	2,109	594	1,525
Total Clarithromycin	25,317	15,678	10,639
Plan Target	25,400	14,900	(11,500)
Variance Fav(Unif) vs. target	83	(778)	(861)

Key Milestones / Announcements	'00 AGU	'01 PLAN	Status
Extended Release Once/Day			
• Initiate BAL study Label addition for Blain XL	--	800	Complete
• Initiate Mucolytic - Private IND Studies (Investig. Initiated)	--	900	Complete
• Initiate Immunomodulatory Program - Private IND Studies (Investig. Initiated)	--	900	Complete
• Initiate Pericapsule study (Investigator Initiated)	--	TBD	
PARD	AGU	'01 PLAN	Status
• Patient protection effort for XL and MR formulations	100	101	Ongoing
	AGU	2001 PLAN	2001 vs AGU Exp(Ind)
• Budget (\$000)	879	335	544
• Analytical Development & Support	2,061	231	1,830
• Formulation Development & Support	298	358	(59)
• Clinical Finishing	320	137	183
• Project Mgt.	3,559	1,061	2,498
Total			Other 47
			2,498

VENDOR MANAGEMENT (Total Department)

- Expenses:
- \$11,898M (Increase of \$3,944M vs 2000 Actual); Includes AMT-452 Milestone payment of \$3MM.
- \$3MM Milestone Payment
- Total Month = 61, unchanged vs. AGU. Abbrev full time = 34, unchanged vs. AGU.

SAPD Resourcemantra				
AGU	Kps	Heads	Man's Cost	Total Cost
2001	0	0	325	325 A
	0	0	0	0

A) Project budget does not include Phase IV bulk drug development expense (process improvement) of \$4.7MM; \$325M included in AGU for 14-0H metabolite.

Domestic Studies	1st Patient Dosed	Last CRF	ROSS 2000 AGU Start	ROSS 2001 PLAN Start	Study Total	Cost(\$000) '00 ACT	'01 PLAN	2001 Fav(Unif.) vs. AGU
Accrual Adjustments - Completed Studies			Start	End		(2,529)	0	(2,529)
Extended Release Once/Day								
MR-456 Blain XL vs. Augmentin in AECB (300 pts)	9/99	4/00	9/99	4/00	3,900	1,277	0	1,277
MR-477 Blain XL vs. Levofloxacin in CAP (replace Trova 300 pts)	9/99	7/00	9/99	7/00	4,000	2,333	0	2,333
MR-483 Blain XL + Ceph. IV Step Down study vs Lev. (150 pts)	1/00	12/00	1/00	12/00	500	357	500	(143)
MR-466B Blain XL Immunomodulatory Claims	1/00	12/00	1/00	12/00	500	527	0	527
MR-208 Blain XL Mucolytic - Private IND Studies (Inv. Init. ; 30 pts.)	9/00	12/01	9/00	12/01	180	0	180 *	(180)
MR-208 Blain XL Mucolytic - Private IND Studies (Inv. Init. ; 50 pts.)	9/00	12/01	9/00	12/01	180	0	180 *	(180)
MR-207 Blain XL Immunomodulatory - Private IND (Inv. Init. ; 100 pts. TB	3/00	12/02	3/00	12/01	880	0	880 *	(880)
* Note: MR-208, MR-207, MR-208 continuations of MR-466B								
MR-214 BAL study Label addition for Blain XL (45 patients)	8/00	4/01	8/00	4/01	350	350	0	350
TBD Pericapsule Investigator Initiated study (patients TBD)	TBD	TBD	TBD	TBD	150	0	150	(150)
NIA Counter Resistance - Animal In Vitro studies CAP registry	NIA	NIA	NIA	NIA	500	0	1,050	(1,050)
International								
MR-317 PREP/RSF IR	11/99	8/00	11/99	8/00	3,249	2,500	749	1,751
Pediatric (International)								
Multiple AI Ped Once-A-Day	1/00	12/02	1/00	12/02	6,707	1,300	0	1,300
Other (International)								
Multiple AI 1 Gram PK Studies	1/00	12/02	1/00	12/02	2,790	850	0	850
Multiple AI Japan 400MG Tablet	1/00	12/02	1/00	12/02	3,488	1,033	0	1,033
Multiple Clar MR	1/01	12/01	1/01	12/01	0	0	0	0
Multiple Clar OD XL vs. MR	4/00	12/02	4/00	12/02	9,056	550	5705	(5,155)
MECAPP						0	848	(848)
Italy Virease (Included in Domestic - Immunomodulatory)						0	0	0

ROSS 2000 AGU: 25,317; 2001 PLAN: 15,678; Variance: 10,639

ROSS 2001 PLAN: 15,678; Variance: 10,639

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ANTI-INFEKTIVE FRANCHISE
Ketotifen ABBT-773
2001 PLAN KEY STATISTICS
(\$000)

Category	2000 Actual	2001 PLAN	2001 PLAN vs. 2000 Actual
KETOTIFEN ABBT-773			
Tablet	17,187	16,574	(613)
Pediatric	2,882	1	2,874
Japan Formulation/Registration	2,857	1,828	1,029
N	1,000	84	916
Target	74,528	90,275	(15,744)
Variance Fav(Unfav.) vs. Target	74,108	88,000	(3,892)
	(428) A	(2,275) B	(1,846)
<p>A) Unfunded IV Project responsible for variance from target. B) Variance expected to be reduced in APV by reduction of one SPD bulk drug campaign (\$1,500K) and reduction in international support to Japan registration (\$1,400K). C) Japan Registration estimate for 2001 assumes delay in Phase III studies in 2002.</p>			
Key Milestones / Assumptions	20 AGU	21 PLAN	
Complete Phase II	8/00	8/00	Complete
End of Phase II - FDA Meeting	10/00	12/00	Complete; Protocol changes will delay Europe start.
Initiate Phase III - North America / Europe	11/00	11/00	Phase II delayed; Studies will start Q2 01, Europe 1Q 01
Initiate Phase III - South Africa / South America	4/01	4/01	Additional sites to achieve required patients by NDA filing date
Pediatric Formulation Co / No-Co	8/00	11/00	No funding for Pediatric in 2001.
SPD Bulk Drug: (Year 2001: 5 deliveries of 233KG @1,673KG Total)	10/1-12/01	10/1-12/01	Discussing with SPD the possibility for reduction of one delivery
Initiate Phase III CAP / Simultaneous comparator studies	8/01	11/01	On target (Based on CAP / Simultaneous 150mg QD vs. 150mg BID results).
File Tablet NDA	8/02	8/02	NDA Filing delayed to 7Q 2002
File Pediatric and IV NDAs	7/02	7/02	No funding for Pediatric or IV in 2001 Plan.
PHASE	20 AGU	21 PLAN	Status (on target, pending or delayed to 2)
Scale Up activities TSL	9/99-1/00	9/99-1/00	Complete
Intermediate scale up 2001	12/99-2/00	12/99-2/00	Complete
Budget			2001 Plan vs. AGU Fav(Unfav.)
Analytical Development & Support	2,081	1,722	359
Formulation Development & Support	2,223	1,436	787
Clinical Publishing	1,945	1,478	467
Project Mgt.	547	507	(40)
Total	6,796	5,143	1,653

Vendor's Commitments

Expenditure: \$12,629K (increase of \$2,584M vs 2000 Actual; includes ABBT-482 Milestone payment of \$3MM).

Total Heads - 41, unchanged vs. AGU. Abbott full time - 38, unchanged vs. AGU.

Category	Kgs	Heads	Direct Cost	Task	Total Cost
2000 AGU	233.0	25	18,808	8	(2,100)
2001 PLAN	1,875	22	1,408	14,800	(1,800)
<p>A) 2190 Kgs for Tablet Formulation, 242 Kgs for Pediatric, 80 Kgs for IV at \$7,500/Kg. Total CAPD costs include headcount related charges of \$7,200K. B) 2,500 Kgs @ \$7,000/Kg for \$17,500K less net prepaying \$2,100K, (\$15,400K net of cost). C) 1,875 Kgs @ \$3,000/Kg + headcount and prepaying charges of \$6,365K. Does not reflect planned reduction of one bulk drug campaign.</p>					

Study	1st Patient Dosed	Last Dosed	CRF	ROSS 2000 AGU		ROSS 2001 PLAN		Study Total	Cost (2000)		2001 Fav(Unfav.) vs. AGU
				Start	End	Start	End		2000 Act.	2001 PLAN	
ACPRU STUDIES (Initiated in 2000)											
Site 2001-1200L	5-01					5-01	12-01	218			(218)
Site 2001-400L BE	11-01					11-01	8-02	221			(221)
Drug Interaction Lorazepam - (delayed to 2002)	7/00					7/00	7/00	175			
Drug Interaction Warfarin	3-01					2-01	8-01	214			(214)
Drug Interaction Digoxin	1-01					1-01	7-01	372			(372)
Drug Interaction Cefazolin (delayed to 2002)	7/00					7/00	7/00	215			
Drug Interaction Cyclosporin (delayed to 2002)	7/00					7/00	7/00	289			
Drug Interaction Celecoxib P17	10-01					10-01	10-02	162			(162)
ABB-773 Site 05L in 2001	5-01					5-01	10-01	175			(175)
ACPRU Total New 2001 Studies											(1,270)
									1,370		
PHASE III STUDIES											
CAP	8-99	8/00	8-99	8/00	8-99	8/00	8/00	4,089	1,837		1,837
Stressor	8-99	8/00	8-99	8/00	8-99	8/00	8/00	3,172	1,538		1,538
ASCB	8-99	8/00	8-99	8/00	8-99	8/00	8/00	3,885	2,212		2,212
Wiring								210	157		157
TOTAL PHASE III STUDIES									11,356	5,544	5,544
2000 External Site Studies											
Japan Phase I	12/99	4/00	12/99	4/00	12/99	4/00	4/00	857	730		730
Tissue Studies	3/00	12/00	3/00	12/00	3/00	12/00	12/00	489	489		489
Tissue Study - Cefix - 150mg	3/01	12/01	3/01	12/01	3/01	12/01	12/01	580			(580)
Tissue Study - Cefix - 150mg QD vs. 150mg BID	3/01	12/01	3/01	12/01	3/01	12/01	12/01	580			(580)
Resol	3/00	2/01	3/00	2/01	3/00	2/01	2/01	380	89		(89)
Hepatic	3/00	2/01	3/00	2/01	3/00	2/01	2/01	313	231		231
								2,529	1,575		1,575
JAPAN STUDIES (New Formulation)											
Japan Phase I	10/00	5/01	10/00	5/01	10/00	5/01	5/01	1,600	1,600		1,600
Japan Phase III					8/01	4/02		22,080			(22,080)
								23,680	1,600		1,600
PHASE II STUDIES											
Multiple	8/00	8/00	8/00	8/00	8/00	8/00	8/00	1,306	1,306		1,306
M00-221 (M00-087)	8/01	3/02	8/01	3/02	11/01	5/02	5/02	2,700		2,343	(2,343)
M00-218 (M00-052)	11/00	8/01	11/00	8/01	11/00	8/01	8/01	18,298	3,535	12,791	(12,791)
M00-220 (M00-051)	8/01	3/02	8/01	3/02	11/01	5/02	5/02	5,780		1,828	(1,828)
M00-229 (M00-149)	8/01	3/02	8/01	3/02	11/01	5/02	5/02	4,400		1,287	(1,287)
M00-225 (M00-087)	11/00	8/01	11/00	8/01	11/00	8/01	8/01	9,258	2,037	7,219	(7,219)
M00-219 (M00-150)	8/01	3/02	8/01	3/02	11/01	5/02	5/02	5,307		1,514	(1,514)
M00-288	8/01	8/02			4/01	8/03		858		310	(310)
M00-218 (M00-088)	11/00	8/01	11/00	8/01	11/00	8/01	8/01	7,721	1,300	5,791	(5,791)
M00-217 (M00-143)	11/00	8/01	11/00	8/01	11/00	8/01	8/01	5,224	1,188	4,036	(4,036)
M00-223 (M00-090)	11/00	8/01	11/00	8/01	11/00	8/01	8/01	4,738	1,185	3,554	(3,554)
M00-222 (M00-157)	11/00	8/01	11/00	8/01	11/00	8/01	8/01	4,629	1,054	3,575	(3,575)
								73,591	12,233	61,358	(61,358)
Other Studies											
A.D. Line Pediatric Taste Testing	3/00	2/01	3/00	2/01	3/00	2/01	2/01	270	225	45	45
Completed Pediatric Prototype Studies	8/00	12/00	8/00	12/00	8/00	12/00	12/00	225	(250)		(250)
Microbiology PK/PD Studies	1/00	12/01	1/00	12/01	1/00	12/01	12/01	3,500	1,811	2,000	(2,000)
Pediatric PK/PD, Phase II	8/00	8/00	8/00	8/00	8/00	8/00	8/00	1,500	301		301
GRAND TOTAL (EXCLUDING ACPRU)								116,541	22,085	47,484	(47,484)

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**ANTI-INFECTION FRANCHISE
QUINOLONE ABT-432
2001 PLAN KEY STATISTICS
(\$000)**

Indication	2000 Actual	2001 PLAN	2001 PLAN Fav(Unfav) vs. Actual
Development	7,063	21,341	(14,278)
Milestone Payment (Phase IIA)	0	3,000	(3,000)
Total Quinolone	7,063	24,341	(17,278)
Target	6,800	25,000	(18,200)
Variance Fav(Unf) vs. target	(263)	659	922

Key Milestone / Assumption	'00 AGU	'01 PLAN	Status
• INITIATE PHASE I STUDIES	4Q '00	4Q '00	Complete
• INITIATE PHASE IIA SAFETY STUDY	—	3Q '01	On target
• NDA Filing	4Q '03	4Q '04	Delayed one year due to funding limitation.

PARD	'00 AGU	'01 PLAN	
• Formulation Development	—	1Q'01	On target
• IIC Phase II	—	5Q'01	On target
• PARD Commercial	—	—	—

Budget (PARD)	'00 AGU	'01 PLAN	Fav(Unf)
• Analytical Development & Support	225	515	(290)
• Formulation Development & Support	274	341	(67)
• Clinical Finishing	36	10	26
• Project Mgt.	59	85	(26)
Total	594	951	(357)

Venture Management (Total Department)

- Expense: \$14,628 (increase of \$3,56M vs 2000 Actual); includes ABT-432 Milestone payment of \$3M.
- Total Heads - 41, unchanged vs. AGU. Abbott full time - 28, unchanged vs. AGU.

CAPD Requirements	Pilot	Plant	Personnel	Total Cost
AGU	0	0.5	480	598 A
2001 PLAN	600	6.0	1892	5,762 B

A) CAPD Pilot Plant 12 weeks @ \$40M/week and 1 person for 6 months
B) CAPD Pilot Plant 44 weeks @ \$43M/week, 6 headcount @ \$245M, 600kg of bulk drug.

	1st Patient Dosed	Last CRF	ROSS 2000 AGU Start	ROSS 2001 PLAN End	Study Start	Study End	Study Total	Cost(\$000) 2000 Act.	Cost(\$000) 2001 PLAN	2001 Fav(Unfav.) vs. 2000 Act.
Phase I										
Single Dose/ Food Effect in Healthy Volunteers (100 pat)	11/00	01/01	4Q 2000	4Q 2000	9/00	01/01	850	680	170	510
Multiple Rising Doses in Healthy Volunteers (50 patients)	01/01	03/01	4Q 2000	4Q 2000	02/01	06/01	500	0	500	(500)
Phase IA / Bio Studies (3 studies)			04/01	09/01	04/01	09/01	700		700	(700)
PHASE I TOTALS							2,050	680	1,370	(690)
Microbiology Studies							710	0	710	(710)
Phase IIA										
AECB (250 patients)	06/01	04/02			08/01	04/02	3,750	0	2,063	(2,063)
SUBTOTAL PHASE I / PHASE IIA							6,510	680	4,163	(3,463)
Phase IIR										
CAP (250 patients)	11/01	07/02			11/01	07/02	3,750	0	637	(637)
Uncomplicated UTI (300 patients)	01/02	09/02			01/02	09/02	1,650	0	0	0
Skin and Skin Structure Infection (300 patients)	01/02	12/02			01/02	12/02	2,100	0	0	0
PHASE II B TOTAL							7,500	0	637	(637)
Total							14,010	680	5,000	(4,320)

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**ANTI-INFECTIVE FRANCHISE
OMNICEF
2001 PLAN KEY STATISTICS
(\$000)**

Indication	2000 AGU	2001 PLAN	2001 PLAN Fav/(Unfav) vs. AGU
Development	0	4,843	(4,843)
Total	0	4,843	(4,843)
Target	0	5,000	(5,000)
Variance Fav/(Unf) vs. target	0	157	157

Key Milestones / Assumptions	'00 AGU	'01 PLAN	Status
• INITIATE ACUTE OTITIS MEDIA STUDY		09/01	On Target

PARD	'00 AGU	'01 AGU	Status
• To be defined			
• Budget			
• Clinical Finishing			
• Project Mgt.			
Total	0	92	(92)

Venue Management (Total Department)

- Expense: \$12,288 (Increase of \$3,848 vs 2000 Actual; includes ANT-492 Milestone payment of \$3,848, \$12M Milestone Payment)
- Total Heads - 41, unchanged vs. AGU. Abbott full time - 33, unchanged vs. AGU.

CAPD Requirements	Kps	Heads	Pilot	Personnel	Total Cost
AGU	0	0	0	0	0
2001 PLAN	0	0.0	0	0	0

	1st Patient Dosed	Last CRF	R/OSS 2000 AGU Start	R/OSS 2000 AGU End	R/OSS 2001 PLAN Start	R/OSS 2001 PLAN End	Study Total	Cost(\$000) 2000 AGU	Cost(\$000) 2001 PLAN	2001 Fav/(Unfav.) vs. AGU
Phase IV										
Acute Otitis Media 3 Arm SD QD BID vs. Zithromax (250 pd)	06/01	07/02			06/01	05/02	6,000		3,000	(3,000)
PHASE IV TOTALS							6,000		3,000	(3,000)
Total							6,000		3,000	(3,000)

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UROLOGY
KCO ABT-598
2001 PLAN KEY STATISTICS
(\$000)

Project	2001 Target	2000 AGU	2001 PLAN	PLAN vs TARGET Fav(Unfav) Var
Project Name KCO ABT-598	4500	0	4960	(460)

Key Milestones / Assumptions	00 AGU	01 PLAN	Status (on target, pending or delayed to x)
First Study	N/A	11/01	On target to PLAN
Second Study	N/A	5/02	On target to PLAN
Feasibility of ER Prototypes completed	N/A	11/02	On target to PLAN
Go/No go Decision	N/A	11/02	On target to PLAN

PARD	00 AGU	01 PLAN	Support Discovery
Analytics Dev & Support	326		
Formulation Dev & Support	221		
Clinical Finishing	56		
Project Management Support	43		
PARD Total	646		

Total Venture Management	00 AGU	01 PLAN	Support Discovery
Expense: Plan expense at \$1,328.			
Authorized Heads: D-42U headcount at 14. KCO estimated equivalents 5.9			

Clinical Grants	Study Name	Start	End	Cost
Pre-Phase I	SD Escalating Dose	11/01	2/02	380
TBD	Rate of Rise	5/02	8/02	
Phase I				

Phase II

Phase III

Total

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760 380 (380)

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ANTI-VIRAL
KALETRA ABT-378
2001 PLAN KEY STATISTICS
(3000)

ONCOLOGY GROUP
ATRASENTAN (ABT-827)
2001 PLAN KEY STATISTICS
 (\$000)

Project	2001 Target	2000 AGU	2001 PLAN	PLAN vs Target Fav(Unfav) Var
Endothelin Antagonist	39,200	13,000	39,043	557

Key Milestones / Assumptions

- Phase III Pivotal Study (M00-211)
- Initiate Phase III Pivotal Study #2 (M00-244)
- QIC, Bioequivalence and Drug Interactions

Status (on target, pending or delayed to x)
 Delayed to 8/01.
 Delayed to 8/01.
 On target

PARO

- Analytics Dev & Support
- Formulation Dev & Support
- Clinical Finishing
- Project Management Support
- PARO Total

00 AGU	01 PLAN	NOEL
601	1,655	NOEL
440	833	NDA file and stability support, plus clinical study supply and re-supply.
67	1,019	
69	185	
1,159	3,602	

Total Venture Management

- Expenses: \$7,246M of \$11,712M
- Authorized Heads: 38 Regular and 9 Other

2000 AGU	2001 PLAN	Head	Man Cost	Total Cost
30	2	2	115	350
2001 PLAN	2	2	115	683

No such activities are planned; please justification and continue

Clinical Grants	1st Patient Dosed	Last CRF	Phase		Start	End	Cost		
			2000 AGU	2001 PLAN			Total	00 AGU	01 PLAN

Phase II

- M98-594 European PCA Study
- M97-739 Open Extension of 500 & 594
- Clin Pharm QTo
- Clin Pharm Bioequivalence
- Clin Pharm Drug Interaction - Midazolam
- Clin Pharm Drug Interaction - Ketoconazole
- Clin Pharm Drug Interaction - Fexofenadine
- Clin Pharm Drug Interaction - Piliampin

2000 AGU	2001 PLAN	Start	End	Total	00 AGU	01 PLAN	Variance
8/87	12/98	8/87	12/00	9,858	...	...	...
1/98	12/00	1/98	12/00	3,200	...	...	...
4/01	n/a	4/01	12/01	281	...	281	(281)
8/01	n/a	8/01	12/01	321	...	321	(321)
10/02	n/a	10/02	30/02	0	...	...	...
10/02	n/a	10/02	30/02	0	...	...	...
4/01	n/a	4/01	8/01	182	...	182	(182)
10/02	n/a	10/02	30/02	0	...	...	...

Phase III

- M00-211 Phase III Pivotal #1
- M00-244 Phase III Pivotal #2
- M00-255 M00-211 & M00-244 LT Extension
- TBD Compassionate Use

2000 AGU	2001 PLAN	Start	End	Total	00 AGU	01 PLAN	Variance
12/00	8/03	12/00	8/03	39,338	1,950	12,420	(10,470)
...	36,000	...	6,898	(5,898)
...	11,000	...	848	(848)
...	2,000	...	288	(288)
...	784	...	784	...
...	100,394	1,950	18,252	(17,302)

Less Clin Pharm studies

Total

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Deposition Exhibit 22

P's Exhibit MB

Part 2

ONCOLOGY GROUP
TSP (ABT-510)
2001 PLAN KEY STATISTICS
(\$000)

Item	2001 Target	2000 AGU	2001 PLAN	PLAN vs Target Fav(Unfav) Var				
	9,000	6,600	9,981	(981)				
Antiangiogenesis Thrombospondin								
Milestones / Assumptions								
Multiple Phase I Multiple Dose Study Pre-IND Meeting Multiple IND Study	00 AGU	01 PLAN	Status (on target, pending or delayed (o x))					
	9/00	2/01	Delayed - Accommodate European Ethics Committee					
	-	2Q/01	On Target					
	-	6/01	On Target					
RD								
Analytics Dev & Support Formulation Dev & Support Initial Finishing Project Management Support PARF Total	00 AGU	01 PLAN	Total					
	391	525						
	211	355						
	74	165						
	86	105						
	762	1,150						
Al Ventura Management								
Expense: \$625M of \$11.712M								
Authorized Heads: 36 Regular and 9 Other								
SPD Requirements								
	Kgs	Heads	Matt Cost	Total Cost				
2000 AGU	7	5	480	2,538				
2001 PLAN	7	5	480	2,538				
Global Grants								
1st Patient Dosed	Last CRF		R/loss					
	2000 AGU		2001 PLAN					
100-153	Start		End					
	9/00		5/01					
1/A	Start		End					
	5/00		3/01					
1/A	Start		End					
					
BD	Start		End					
					
Multiple Dose In Cancer Patients University of Texas - Dr. Fidler University of Texas - Dr. Fidler IND Study	2/01	11/01	10/00	11/01	1,236	700	872	(272)
	5/00	3/01	300	225	81	144
	2/02	300	...	218	(218)
	6/01	1/02	6/01	1/02	400	...	350	(350)
				
					2,236	925	1,821	(696)
				
				
				

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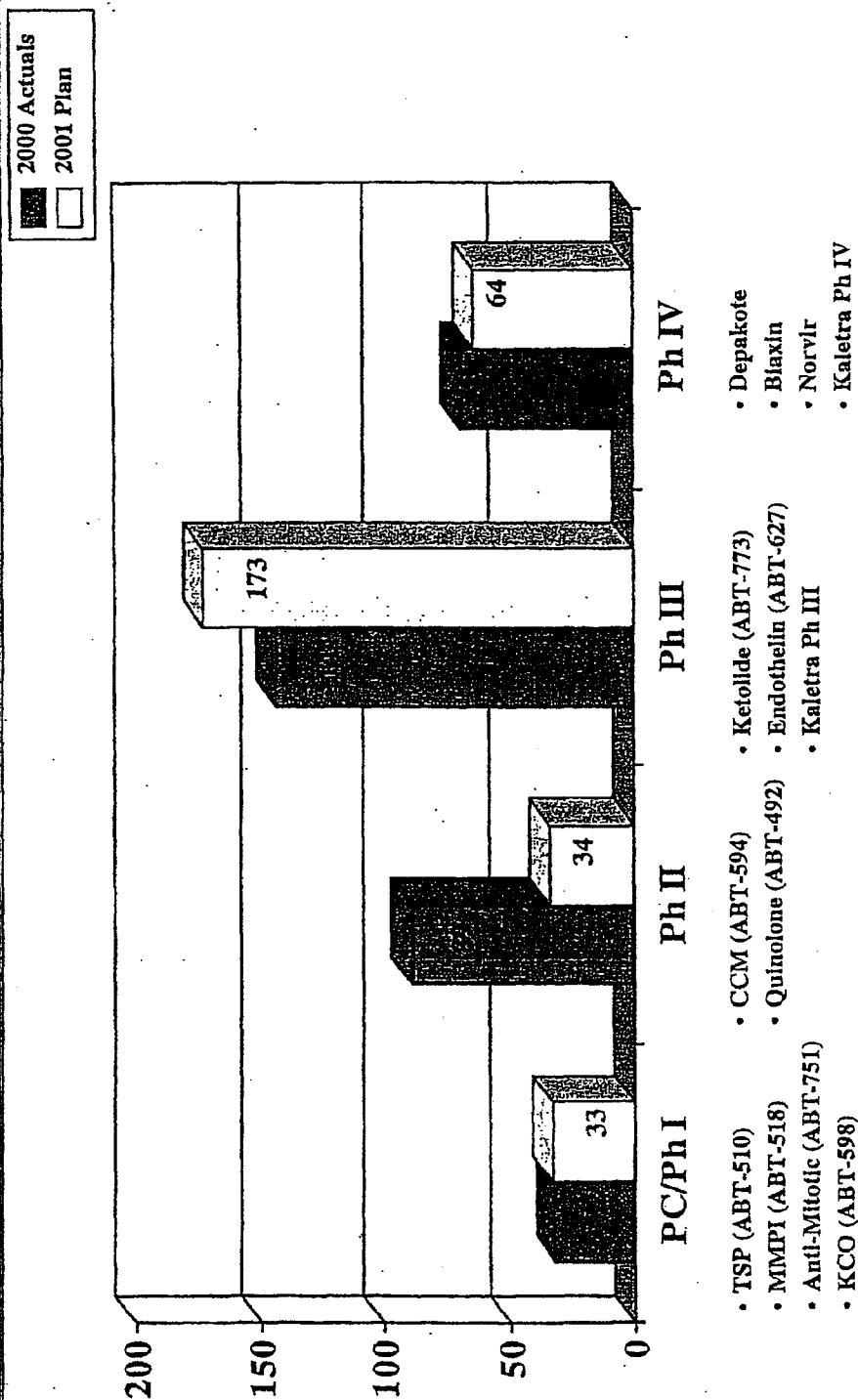
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R&D Spending by Phase



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**Global Pharmaceutical Research & Development
Funding by Phase
2001 PLAN**

	2000 Actuals	2001 PLAN
Phase I		
COX-II	2.7	1.2
ABT-099 (formerly OICM)	1.6	0.6
ABT-103	...	...
NPB-1776	...	...
Dulcitol	7.1	...
Neuraminidase	2.8	...
KCO	...	5.0
TSP #1	7.0	10.0
MMP-1	5.8	7.4
Anti-Mitotic	3.9	6.4
K-5	1.0	...
Subtotal Phase I	31.7	32.8
Phase II		
ABT-594	14.3	9.3
Kalera	55.9	...
Quinone	...	24.5
NS-40	1.9	...
Endothelin	19.8	...
Subtotal Phase II	82.9	33.8
Phase III		
Kalera	18.8	88.0
SP-1 Backup	31.5	2.3
Kalera	80.8	44.2
Cyclosporine	13.8	...
Endothelin	...	38.8
Subtotal Phase III	144.4	173.3
Phase IV		
Depakote	33.6	24.1
Gabril	...	1.4
Hydrocodone	...	4.0
Claritromycin	23.4	14.9
Omnicef	...	4.9
Fenofibrate	2.2	1.4
Ritonavir	10.1	4.0
Kalera	...	9.8
Cyclosporine	...	2.5
Subtotal Phase IV	68.3	64.0
Other		
Discovery	190.6	192.0
Global Other	34.4	86.1
Subtotal Other	225.0	278.1
Affordability	...	(8.8)

*Excluding Sister Divisions

1/28/00/Phase II/Report by Phase II/Actual/Plan

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Target Detail/ Book Pages to PPD

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2001 PLAN
Global Pharmaceutical Research & Development
R&D/Medical Expenses Summary
(\$000)

	2000 Actual	2000 AGU	2001 PLAN	2001 PLAN Fav/(Unfav) vs 2000 AGU	Memo: Global R&D
Discovery	190,618	184,760	192,000	(7,250)	192,000
Global Development	313,302	318,565	328,307	(9,742) (A)	328,307
Domestic Development	55,441	55,183	51,729	3,454	
Gross PPD	559,361	558,498	572,036	(13,538)	520,307
TAP and Sister Division	65,276	67,809	57,348	10,461	
Total Gross Expense	624,636	626,307	629,384	(3,077)	
Net PPD	375,593	374,730	385,367	(10,637)	208,124
Expense by Classification:					
Salaries/Fringe/Contract	204,133	207,042	222,483	(15,441)	
Travel/Meetings	8,452	7,800	8,327	(527)	
Other Employee Related	9,274	8,989	9,901	(902)	
MIS	5,074	5,074	5,074	...	
Corp Allocation	21,869	21,894	22,924	(1,030)	
Other	375,834	378,140	370,439	8,701 (A)	
Affordability	...	(3,642)	(9,764)	6,122	
Total Expense	624,636	626,307	629,384	(3,077)	

Commentary:

(A) Primarily due to increased support for Quinolone, Ketolide and Endothelin.

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2001 PLAN (FNUAL)
PHARMACEUTICAL PRODUCTS RESEARCH & DEVELOPMENT
GLOBAL/DOMESTIC SPLIT
(\$MM)

FRANCHISES	Actuals through 2000		2000 AGU		2001 PLAN		PLAN VS AGU (UNF)	
	GROSS	PPD	GROSS	PPD	GROSS	PPD	GROSS	PPD
NEUROLOGY								
Dopivets	170.9	179.9	30.4	30.4	24.1	24.1	6.3	6.3
Gabril	136.5	122.9	2.0	1.8	1.4	1.3	0.6	0.5
Act-24 (formerly CCW)	62.2	37.3	14.4	8.8	9.3	5.8	6.1	3.0 (A)
CDX-11	2.7	1.6	4.0	2.4	1.2	0.7	2.8	1.7
Act-08 (formerly CRCA)	1.6	1.0	3.0	1.8	0.6	0.4	2.4	1.4
Act-15	...	...	...	...	...	...	...	...
NPB-1776	...	...	...	...	...	...	...	...
RP Schick / Alza (Hydrocodone)	...	...	...	...	...	...	...	...
RP Subtotal NEUROLOGY	362.9	342.7	53.6	48.9	40.8	36.1	12.8	6.8
ANTI-INFECTION								
Chloramphenicol	393.6	238.3	28.4	15.8	14.9	8.8	11.5	6.8
Keloids	...	...	74.1	44.5	99.0	52.8	(13.9)	(8.3) (C)
Keloids Test	...	...	(7.0)	(4.2)	...	...	(7.0)	(4.2)
Quinolone	11.8	7.0	6.8	4.1	24.5	14.7	(17.7)	(10.6) (D)
Neuraminidase	...	...	2.5	1.5	...	...	2.5	1.5
Omnicef	...	...	...	...	...	...	...	...
Subtotal ANTI INFECTION	889.2	538.6	102.8	61.7	133.3	81.3	(4.9)	(4.8)
UROLOGY/CARDIOLOGY								
BPH Backup	65.7	61.4	34.0	20.4	2.3	1.4	31.7	19.0 (E)
Fenofibrate (Fournier)	14.1	14.1	1.0	1.0	1.4	1.4	(0.4)	(0.4)
Nippon Shinyaku (NS48)	12.3	7.4	2.7	2.2	...	...	2.7	2.2
KCD	...	...	...	...	5.0	4.0	(5.0)	(4.0)
Subtotal UROLOGY/CARDIOLOGY	112.1	72.9	37.7	23.8	8.7	6.8	29.0	16.8
HIV								
Ritonavir	299.3	178.8	13.0	7.8	4.0	2.4	9.0	5.4
Kalera	215.7	129.4	76.6	48.7	51.0	30.8	25.6	18.1 (E)
Cyclosporine	91.0	38.8	11.7	8.4	2.5	1.5	9.2	6.9
Subtotal HIV	571.8	346.6	101.2	62.9	57.6	34.9	43.7	28.4
CANCER								
Erdotinib	98.4	57.8	13.0	7.8	38.8	23.3	(25.8)	(15.5) (C)
TSP #1	11.0	8.6	8.8	4.0	10.0	4.0	(1.2)	(1.2)
Metoprolol	5.8	3.4	6.0	3.0	7.4	4.4	(2.4)	(1.4)
Anti-Arthritis	3.9	2.3	6.0	4.8	8.4	5.0	(2.4)	(0.2)
K-3	1.0	0.8	1.0	0.8	...	...	1.0	0.8
FTI #2	...	...	...	...	...	...	...	...
Subtotal CANCER	117.9	70.7	31.8	28.2	64.8	38.7	(33.0)	(18.4)
Other New Products								
Other	n/a	n/a	...	...	...	...	...	...
Affordability	n/a	n/a	60.3	52.6	66.1	78.7	(35.9)	(28.2)
	n/a	n/a	(3.6)	(2.2)	(4.8)	(5.9)	6.2	3.7
Total Development	n/a	n/a	372.8	283.6	360.0	270.2	(6.3)	(6.4)
Discovery	n/a	n/a	184.8	110.9	192.0	115.2	(7.3)	(4.3)
Total Gross/Net PPD	n/a	n/a	888.8	514.7	872.8	535.4	(13.8)	(19.1)

Comments:
(A) Funding assumes No Go decision at 20 2001 decision point
(B) BPH Backup project was killed 1000 and reflects shut down expenses in 2001
(C) Reflects higher costs associated with Phase III
(D) Reflects higher costs associated with Phase II
(E) Decrease reflects year 2000 launch

Continued on next page

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PHARMACEUTICAL PRODUCTS RESEARCH & DEVELOPMENT
GLOBAL ALI SPLIT
(\$MILLIONS)

	2009 PLAN		2008 PLAN	
	Global	Domestic	Global	Domestic
NEUROLOGY				
Dyslexia	0.5	32.7	—	24.1
Gabril	0.5	1.5	—	1.4
ABT-594 (family CCM)	15.0	—	—	9.3
Con-B	—	—	—	1.3
ABT-689 (family OCM)	—	—	—	6.6
ABT-103	—	—	—	—
ABT-176	—	—	—	—
PF-03809506 / Adu (hydrocodone)	—	—	—	4.0
ANTI-INFECTIVE	15.5	34.3	11.7	37.5
Chlorhexidine	32.0	—	—	—
Kidney	71.3	—	14.9	—
Quelone	14.0	—	8.0	—
Neurocholine	3.8	—	24.5	—
Oncoher	—	—	—	—
UROLOGY/CARDIOLOGY	112.1	—	127.4	4.0
BPH/BKBP	38.0	—	5.3	—
Thior (Furofuran)	5.2	2.0	—	1.4
Nipen Rhinopore (NS-49)	3.2	—	—	—
CCO	4.3	—	—	—
HIV	43.3	7.2	5.0	1.4
Maraviroc	13.0	—	4.0	—
Kelme	74.4	—	51.0	—
Cystoprine	7.9	4.1	2.3	—
CANCER	93.3	4.1	57.5	—
Endothelin	6.0	—	—	—
Metoprolol (MOPR)	5.0	—	31.8	—
Penicillamine (FTI) #2	3.8	—	7.4	—
TSP #1	5.0	—	10.0	—
TSP #2	1.9	—	—	—
Anti-Minor	5.9	—	8.4	—
KJ	—	—	—	—
Other New Products	7.2	—	44.6	—
Other	92.5	16.1	48.7	17.2
Total Development	357.8	41.6	334.8	83.9
Discovery	185.0	—	192.0	—
Total PPD (With Risk)	542.8	61.6	526.8	83.9
Risk/Affordability	(44.3)	(5.3)	(1.3)	(1.3)
Total PPD (With Risk)	497.5	56.3	525.5	82.6
AI Split as Calculated @ 40%	198.8	—	208.1	—
AI Split per IDV	181.1	—	186.7	—
Under/Over Charge	15.0	—	21.6	—

Book II IDV was \$198,870
Per Jeff McGuire A.I. will pay \$12,000 less
\$198,870 - \$12,000 = \$186,870
208,120 - 186,870 = \$21,250 A.I. Undercharge

Let's make sure we're consistent in the numbers. 1/27/08

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PHARMACEUTICAL PRODUCTS RESEARCH & DEVELOPMENT

	Corporate Submission	Final 2001 PLAN	Final vs. Corp Sub Incl(Dec)
NEUROSCIENCE			
Dipacolate	28.0	24.1	(1.9)
Gabliel	...	1.4	1.4
ABT-594	8.6	9.3	0.4
COX - II	3.0	1.2	(1.8)
ABT-980	7.0	0.8	(8.4)
ABS-103	3.3	...	(3.3)
NPS-1776	3.7	...	(3.7)
RP Scherer / Alza	4.0	4.0	...
Subtotal NEUROLOGY	65.6	40.6	(18.3)
ANTI-INFECTIVE			
Clarithromycin	20.0	14.9	(5.1)
Keloida	91.0	88.0	(3.0)
Quindone	25.0	24.5	(0.5)
Neuraminidase	...	...	...
Omnicef	6.0	4.9	(0.1)
Subtotal ANTI INFECTIVE	141.0	132.3	(8.7)
UROLOGY/CARDIOLOGY			
BPH Backup	25.4	2.3	(23.1)
Fenofibrate (Fournier)	4.0	1.4	(2.6)
Nippon Shinyaku (NS40)	...	...	...
KCO	8.0	8.0	(1.0)
Subtotal UROLOGY/CARDIOLOGY	36.4	8.7	(28.7)
HIV			
Ritonavir	4.0	4.0	...
Kaletra	41.5	51.0	9.5
Cyclosporine	2.0	2.5	0.5
Subtotal HIV	47.5	57.5	10.0
CANCER			
Endothelin	23.0	38.8	15.8
TSP #1	9.0	10.0	1.0
Metalloproteinase	7.0	7.4	0.4
Anti-Mitotic	10.0	8.4	(1.6)
K-6	8.8	...	(8.8)
FTI #2	4.1	...	(4.1)
Subtotal CANCER	61.9	64.6	2.7
Other New Products			
Other	78.6	80.1	7.8
Affordability	(25.1)	(9.8)	15.3
Total Development	385.1	380.0	(16.1)
Discovery	187.0	182.0	(5.0)
Total Gross PPD	682.7	672.0	(20.0)
TAP & Sister Division	69.2	67.4	(1.8)
Total Gross	651.3	639.4	(21.9)

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PRELIMINARY
Pharmaceutical Research & Development
Expense Breakdown
2001 PLAN

Pharmaceutical Products Division - R&D
Summary of R&D Projects
2001 PLAN

Project/Description	Cost thru 2000	2000 Actual	2001 PLAN	Cost until NDA 2001 and Forward
Depakote Development programs to enhance the Depakote/Depacon product position in the treatment of epilepsy, prevention of migraine headaches and the treatment of manic episodes associated with bipolar disorder. This includes a new extended release formulation in each of these treatment areas and studies to expand the market for treating impulsive aggression, psychosis, elderly agitation, a comparator study with Lilly's anti-psychotic drug, Zyprexa, and bipolar in pediatric mania. Additionally, the Depacon Rapid Infusion Study will assess the safety of rapidly loading Depacon in patients with Epilepsy. Two new formulations are being developed - 250 mg ER tablet and DR Spinning Disk.	\$179.9	\$33.6	\$24.1	N/A
ABT-594 [Milestone: Go/No Go Clinical Efficacy, 2Q01, NDA Date: 1Q03] ABT-594 is a non-opioid, non-NSAID analgesic that is a potent and selective neuronal nicotinic receptor modulator. It is effective across all pain conditions: nociceptive pain and neuropathic pain. Preclinical data shows ABT-594 to be 30 to 100 times more potent and equally efficacious to morphine in several well characterized animal models of nociceptive pain. ABT-594 has a unique mechanism of action which may encourage use in combination with other analgesics as well as nontherapy. Indicated for the management of neuropathic pain associated with diabetic polyneuropathy. Indication or publication for specific chronic nociceptive and/or neuropathic pain condition (e.g., OA). Oral formulation expected. Dosing schedule to be determined.	\$62.2	\$14.3	\$9.3	\$71.0
ABT-089 [Milestone: Transition Team Go/No Go, 4Q01] ABT-089 is a potent and selective neuronal nicotinic receptor modulator with respiratory enhancing activity in rodent and primate preclinical models of respiratory dysfunction. It does not appear to have nicotine like dependence liability or abuse. ABT-089 may be the second non-scheduled, non-simultaneous product for the ADHD market. Oral formulation and QD dosing expected.	\$1.6	\$1.6	\$0.6	\$102.3
Carbidromycin The NDA for carbidromycin extended release (Blatch XL) was approved March 3, 2000. New studies planned for the U.S. include Asthma and Cystic Fibrosis. International Projects for 2001 include QD XL, registration studies and the Japan 400mg tablet.	\$393.8	\$23.3	\$14.9	N/A
Ketotide (ABT-773) [Milestone: Phase III CAP/AMS dose range data 2Q01, Tablet NDA 3Q02] ABT-773 is a potent benzamide with strong activity against most macrolide resistant strains while also maintaining the broad spectrum coverage of clarithromycin. Product will be available as tablet followed by a pediatric suspension and injectable form dependent on timing of funding. ABT-773 will address the major unmet medical needs of increasing resistance to current empiric agents and weak activity against key problem pathogens, especially S. pneumoniae. Mainline claim of "Spontaneous" (G+, O-, strict). Cover key O-resistant strains (S. pneumoniae, S. pyogenes). Tablet dosing will be QD or BID based on severity of indications. Five days for ABECB, Pharyngitis, 10 days for AMS and CAP. COGS no more than \$2,500/kg at launch. Pediatric and IV currently not funded.	\$153.8 (Tab)	\$74.5 (Tab)	\$88.0 (Tab)	\$42.0 (Tab US/REU)
Quinolone (ABT-493) [Milestone: Go/No Go PK/Safety (Phase Ia) 2Q01, NDA Date: 4Q04] ABT-493 is a broad-spectrum anti-infective agent with potential application across a range of indications, including respiratory infections, genitourinary infections, and skin/soft tissue infections. Product will initially be available as tablet/suspension followed by an injectable form approximately one year later. The in vitro antibacterial activity of ABT-493 appears to be more potent than levofloxacin. The in vivo potency data suggested that ABT-493 has the potential to be therapeutically effective at doses comparable to levofloxacin. Must have a safety profile comparable to levofloxacin. QD dosing for adult tablet/suspension and IV. Five days for most indications.	\$11.6	\$7.1	\$24.5	\$227.6 (Tab)
Omnicef [Milestone: Initiate Clinical Studies 3Q01, SNDA Q402] Cefdinir (Omnicef) is a potent cephalosporin indicated for the full range of respiratory tract and skin infections, and has 5 day BID indications for AOM, pharyngitis, and AECB. The suspension is pleasant tasting, significantly better than Cefadil and Augmentin in 2 studies, and better than Zithromax in 1 of 2 studies. A new study will pursue claims for 5 day, once daily dosing in AOM, and generate comparative data vs. Zithromax with both once daily and twice daily dosing. A second study is planned for AECB and is currently Blue Plan. Comparator agents are under evaluation. The NDA would be filed Dec 2002.	\$0.0	\$0.0	\$4.9	N/A
Benign Prostatic Hyperplasia Back-up (ABT-980) [Program terminated 1Q00] ABT-980 is a potent alpha selective adrenoceptor antagonist with 130-fold selectivity for alpha 1 versus alpha 2 receptor in the medical treatment of benign prostatic hyperplasia. Indicated for the relief of symptomatic benign prostatic hyperplasia. ABT-980 program had to be terminated in 1Q00 due to the development of serum transaminase elevations in patients.	\$83.7	\$31.5	\$2.3	\$0.0

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**Pharmaceutical Products Division - R&D
Summary of R&D Projects
2001 PLAN**

Project/Description	Cost thru 2000	2000 Actual	2001 PLAN	Cost until NDA 2003 and Forward
Kaletra ABT-378 is a second generation protease inhibitor which will be reformulated in one year with a K _i of 1pm. Phase I studies indicate that ABT-378 is safe and well tolerated at all doses studied. ABT-378 works only in combination with Zalcitabine. Phase II studies of ABT-378 to achieve higher blood levels than on its own. Indicated as first-line treatment for HIV. Phase III studies are ongoing. Safety, side effect, and toxicity profile at least equal to current standard. Dosing: BID, QD possible. Will be available in one reformulated pill with ritonavir.	\$215.7	\$80.8	\$51.0	N/A
Endothelin (ABT-427) [Milestone: Initiate Phase III Clinical Safety, 2Q01] ABT-427 is Abbott's leading endothelin receptor antagonist. ABT-427 is seeking an indication for the treatment of hormone refractory prostate cancer. ABT-427 is orally administered and well tolerated as chronic therapy. It has demonstrated improvement of time to disease progression compared to placebo. It has also demonstrated improvement in time to PSA progression compared to placebo.	\$96.4	\$16.8	\$38.8	\$51.0
FSP #1 (ABT-510) [Milestone: Go/No Go Clinical Safety, 2Q01] ABT-510 is a potent thromboplastic agent. TSP is an angiogenesis inhibitor that may prevent growth of primary tumors as well as prevent the spread of metastases by inhibiting the growth of. Solitarily vascular required to provide blood to growing tumors. With a relatively benign toxicity profile, this class of agents may be used to prevent metastatic disease in patients who have received surgery, radiation or chemotherapy as primary therapy to treat cancer patients. At chronic, long-term therapy, there is potential for significant commercial opportunity.	\$11.0	\$7.0	\$10.0	\$80.5
Metalloproteinase (MMP) (ABT-518) [Milestone: Go/No Go Clinical Safety, 2Q01] ABT-518 is an oral, matrix metalloproteinase inhibitor and a cytostatic agent. MMP's may prevent the growth of metastatic lesions and inhibit primary tumor growth. These agents will most likely be used with current therapy or post-definitive therapy such as surgery, radiation and chemotherapy. As chronic, long-term therapy, there is significant commercial upside.	\$5.6	\$5.6	\$7.4	\$86.3
Anti-Mitotic (Eltan) (ABT-751) [Milestone: Go/No Go Clinical Safety, 2Q01] ABT-751 is an oral tyrosine kinase inhibitor that inhibits tumor growth by inhibiting the polymerization of tubulin into microtubules, a necessary step in cell division. This mechanism of action is somewhat similar to the mechanism of taxanes. This novel agent could produce clinical benefits equal to or superior to current taxanes and could be as commercially successful as current taxanes. ABT-751 also has the potential to be effective in patients experiencing resistance to other agents, including taxanes.	\$3.9	\$3.9	\$8.4	\$78.0
Other Other projects include Glabril, COX-2, ABS-101, NPS-1776, Hydrocodone, Fenofibrate, KCO, Ritonavir, Cyclosporine, CAPD Excess Capacity Charges, and CAPD Ctrial process improvements.	N/A	\$68.6	\$105.6	N/A
Affordability Lifetec Risk	N/A	\$0.0	(\$9.8)	N/A
Discovery Funding provides for five Discovery Development Candidates (DDCs) to be brought forth in 2001. Reflects Discovery costs in Infectious Disease Research, Metabolic Disease Research, Neurological and Urological Disease Research, and Cancer Research. Includes Neuroscience, Kuro Bio, TCGen, IDUN, Incyte and ISIS collaborations.	N/A	\$190.6	\$192.0	N/A
Total Gross PPD	N/A	\$559.4	\$572.0	N/A

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Pharmaceutical Products Division R&D
Plan Getting Followed
Gross Expense

	January	February	March	April	May	June	July	August	September	October	November	December	TOTAL
Reductions													
Other Functional Expenses	(1,524)	(1,522)	(1,000)	(1,240)	(1,540)	(1,140)	(1,140)	(1,170)	(1,300)	(1,200)	(1,250)	(1,240)	(12,490)
R&D Grantee	100	100	100	100	100	100	100	100	100	100	100	100	1,200
Contract	(327)	(327)	(287)	(312)	(340)	(287)	(312)	(317)	(333)	(317)	(333)	(317)	(3,100)
Oncology Grantee	(1,197)	(1,197)	(613)	(928)	(1,140)	(740)	(740)	(753)	(867)	(783)	(817)	(723)	(8,190)
All Other	(1,197)	(1,197)	(613)	(928)	(1,140)	(740)	(740)	(753)	(867)	(783)	(817)	(723)	(8,190)
Total Reductions	(2,024)	(2,029)	(1,387)	(2,350)	(2,780)	(2,077)	(2,080)	(2,120)	(2,367)	(2,080)	(2,267)	(2,160)	(21,470)
Additions													
Other Functional Expenses	342	342	342	342	342	342	342	342	342	342	342	342	4,104
R&D Grantee	342	342	342	342	342	342	342	342	342	342	342	342	4,104
Contract	342	342	342	342	342	342	342	342	342	342	342	342	4,104
Oncology Grantee	342	342	342	342	342	342	342	342	342	342	342	342	4,104
All Other	342	342	342	342	342	342	342	342	342	342	342	342	4,104
Total Additions	342	342	342	342	342	342	342	342	342	342	342	342	4,104
Change in Net Affordability (\$25.1 vs \$25.1)	0	0	0	0	0	0	0	0	0	0	0	0	0
Adjustment													
Adjustment	5,163	5,163	5,163	5,163	5,163	5,163	5,163	5,163	5,163	5,163	5,163	5,163	61,956
Reductions													
Other Functional Expenses	(2,442)	(2,442)	(2,442)	(2,442)	(2,442)	(2,442)	(2,442)	(2,442)	(2,442)	(2,442)	(2,442)	(2,442)	(29,304)
R&D Grantee	(1,442)	(1,442)	(1,442)	(1,442)	(1,442)	(1,442)	(1,442)	(1,442)	(1,442)	(1,442)	(1,442)	(1,442)	(17,304)
Contract	(1,000)	(1,000)	(1,000)	(1,000)	(1,000)	(1,000)	(1,000)	(1,000)	(1,000)	(1,000)	(1,000)	(1,000)	(12,000)
Oncology Grantee	(1,000)	(1,000)	(1,000)	(1,000)	(1,000)	(1,000)	(1,000)	(1,000)	(1,000)	(1,000)	(1,000)	(1,000)	(12,000)
All Other	(1,000)	(1,000)	(1,000)	(1,000)	(1,000)	(1,000)	(1,000)	(1,000)	(1,000)	(1,000)	(1,000)	(1,000)	(12,000)
Total Reductions	(2,442)	(2,442)	(2,442)	(2,442)	(2,442)	(2,442)	(2,442)	(2,442)	(2,442)	(2,442)	(2,442)	(2,442)	(29,304)
Additions													
Other Functional Expenses	322	322	322	322	322	322	322	322	322	322	322	322	3,864
R&D Grantee	322	322	322	322	322	322	322	322	322	322	322	322	3,864
Contract	322	322	322	322	322	322	322	322	322	322	322	322	3,864
Oncology Grantee	322	322	322	322	322	322	322	322	322	322	322	322	3,864
All Other	322	322	322	322	322	322	322	322	322	322	322	322	3,864
Total Additions	322	322	322	322	322	322	322	322	322	322	322	322	3,864
Change in Net Affordability (\$25.1 vs \$25.1)	0	0	0	0	0	0	0	0	0	0	0	0	0
Adjustment													
Adjustment	1,278	1,278	1,278	1,278	1,278	1,278	1,278	1,278	1,278	1,278	1,278	1,278	15,336
Reductions													
Other Functional Expenses	(1,278)	(1,278)	(1,278)	(1,278)	(1,278)	(1,278)	(1,278)	(1,278)	(1,278)	(1,278)	(1,278)	(1,278)	(15,336)
R&D Grantee	(1,278)	(1,278)	(1,278)	(1,278)	(1,278)	(1,278)	(1,278)	(1,278)	(1,278)	(1,278)	(1,278)	(1,278)	(15,336)
Contract	(1,278)	(1,278)	(1,278)	(1,278)	(1,278)	(1,278)	(1,278)	(1,278)	(1,278)	(1,278)	(1,278)	(1,278)	(15,336)
Oncology Grantee	(1,278)	(1,278)	(1,278)	(1,278)	(1,278)	(1,278)	(1,278)	(1,278)	(1,278)	(1,278)	(1,278)	(1,278)	(15,336)
All Other	(1,278)	(1,278)	(1,278)	(1,278)	(1,278)	(1,278)	(1,278)	(1,278)	(1,278)	(1,278)	(1,278)	(1,278)	(15,336)
Total Reductions	(1,278)	(1,278)	(1,278)	(1,278)	(1,278)	(1,278)	(1,278)	(1,278)	(1,278)	(1,278)	(1,278)	(1,278)	(15,336)
Additions													
Other Functional Expenses	1,278	1,278	1,278	1,278	1,278	1,278	1,278	1,278	1,278	1,278	1,278	1,278	15,336
R&D Grantee	1,278	1,278	1,278	1,278	1,278	1,278	1,278	1,278	1,278	1,278	1,278	1,278	15,336
Contract	1,278	1,278	1,278	1,278	1,278	1,278	1,278	1,278	1,278	1,278	1,278	1,278	15,336
Oncology Grantee	1,278	1,278	1,278	1,278	1,278	1,278	1,278	1,278	1,278	1,278	1,278	1,278	15,336
All Other	1,278	1,278	1,278	1,278	1,278	1,278	1,278	1,278	1,278	1,278	1,278	1,278	15,336
Total Additions	1,278	1,278	1,278	1,278	1,278	1,278	1,278	1,278	1,278	1,278	1,278	1,278	15,336
Change in Net Affordability (\$25.1 vs \$25.1)	0	0	0	0	0	0	0	0	0	0	0	0	0
Adjustment													
Adjustment	1,278	1,278	1,278	1,278	1,278	1,278	1,278	1,278	1,278	1,278	1,278	1,278	15,336

Reductions

Plan Plan
N versus 2009 AGU
N versus 2009 AGU
N versus 2009 AGU
N versus 2009 AGU
N versus 2009 AGU
2009 AGU

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Other Miscellaneous Schedules

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Pharmaceutical Products Research & Development
R&D/Medical Expenses Summary
(\$000)

	1998 ACTUAL	1999 ACTUAL	2000 PLAN	2000 APU	2000 AGU	2001 PLAN
Global Discovery	162,565	170,792	185,000	185,000	184,760	192,000
Global Development	263,041	248,488	312,126	327,300	318,565	328,307
Subtotal Global	425,606	419,278	497,126	512,300	503,315	520,307
% growth vs. prior year		-5.5%	25.6%	4.9%	-2.7%	3.1%
A.I. \$ share	170,242	165,911	183,768	183,768	183,768	186,670
A.I. % share	40.0%	39.6%	37.0%	35.9%	36.5%	35.9%
A.I. % share growth		-2.5%	10.8%			1.6%
PPD \$ share	255,364	253,367	313,358	328,532	319,547	333,637
PPD % share	60.0%	60.4%	63.0%	64.1%	63.5%	64.1%
PPD % share growth		-0.8%	23.7%			6.5%
Domestic Development	66,861	63,876	55,290	55,183	55,183	51,729
Gross PPD	492,467	483,154	553,416	567,483	568,498	572,036
TAP and Sister Division	58,700	58,301	52,694	65,459	67,809	57,348
Total Gross Expense	551,167	541,455	606,110	632,942	628,307	629,384
Net PPD	322,225	315,443	369,648	383,815	374,730	385,367

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Detail of "Other"
2001 PLAN

	Drugs			Adjustments			2001 PLAN			2000 AGU			Variance Favor/Unfavor
	Global	Domestic	Total	Global	Domestic	Total	Global	Domestic	Total	Global	Domestic	Total	
Miss PPD R&D													
Alternate Design	118	--	118	--	--	--	118	--	118	2,552	--	2,552	1,881
In Licensing	403	--	403	--	--	--	403	--	403	1,791	--	1,791	1,358
Expenditure Effect	495	--	495	--	--	--	495	--	495	825	--	825	457
Participation for Grants	123	--	123	--	--	--	123	--	123	827	--	827	804
Structural	71	--	71	--	--	--	71	--	71	--	--	--	(73)
MS-19 AST-232	57	--	57	--	--	--	57	--	57	--	--	--	(57)
Macrolides & Penicillins Pro-UK	--	36	36	--	--	--	--	36	36	--	--	--	(36)
Macrolide Protein	--	--	--	7	--	7	7	--	7	7	--	7	--
Drug User Fees	--	--	--	1,207	--	1,207	--	--	--	1,851	--	1,851	744
Patent to Operations	--	--	--	--	--	--	--	--	--	209	--	209	306
Days & Payments not in hand	--	--	--	3,168	--	3,168	3,168	--	3,168	2,309	--	2,309	(857)
Inventory Transfer AST 316	--	--	--	--	--	--	--	--	--	(5,728)	--	(5,728)	(5,728)
Global Supplies (Operations)	--	--	--	200	--	200	200	--	200	200	--	200	--
Compliance	--	--	--	--	--	--	--	--	--	2,440	--	2,440	2,440
EDG/Other	--	--	--	--	--	--	--	--	--	1,500	--	1,500	1,500
IT Productivity Projects	--	--	--	--	--	--	--	--	--	--	--	--	--
Healthcare/Other	--	--	--	--	--	--	--	--	--	1,000	--	1,000	1,000
General PI	--	--	--	--	--	--	--	--	--	500	--	500	500
General R2	--	--	--	--	--	--	--	--	--	--	--	--	--
Compliance	--	--	--	--	--	--	--	--	--	171	--	171	--
CI charge from Ops (Cis Val Mgr)	--	--	--	--	--	--	--	--	--	807	--	807	807
SPD EDV - Licensure	--	--	--	--	--	--	--	--	--	852	--	852	852
Angie Insurance	--	--	--	--	--	--	--	--	--	1,078	--	1,078	1,078
Data Management Absorption	--	--	--	--	--	--	--	--	--	2,850	--	2,850	2,850
Other New Products	--	--	--	--	--	--	--	--	--	148	--	148	148
All Management	--	--	--	--	--	--	--	--	--	--	--	--	--
	1,222	34	1,256	3,373	1,207	4,580	4,605	1,245	5,850	13,412	2,181	15,593	9,713
Non-Processed Products													
Chol	--	2,480	2,480	--	--	--	--	2,480	2,480	--	2,480	2,480	--
AMC	--	2,588	2,588	--	--	--	--	2,588	2,588	--	854	854	(1,734)
New Candidates	--	--	--	--	--	--	--	--	--	--	--	--	--
All Other (Detail Below)	83	3,072	3,155	--	--	--	83	8,073	8,156	1,502	10,881	12,383	4,117
	83	12,121	12,204	--	--	--	83	13,121	13,214	1,502	14,029	15,621	2,407
SPD Miss													
Outstanding	--	--	--	--	--	--	--	--	--	552	--	552	552
Outstanding Asset/Other	--	--	--	--	--	--	--	--	--	--	--	--	--
Household Lab	--	--	--	--	--	--	--	--	--	552	--	552	552
SPD Process													
Unit of Authority Charge	23	--	23	--	--	--	23	--	23	28	--	28	5
Ery A for Chel Impulse	--	369	369	--	--	--	--	369	369	838	--	838	370
Chol Promotes Improve	1,973	--	1,973	--	--	--	1,973	--	1,973	2,907	--	2,907	934
YGO	--	--	--	--	--	--	--	--	--	--	--	--	--
New Project Support	7,152	--	7,152	--	--	--	7,152	--	7,152	--	--	--	(7,152)
Chol - Delivery	--	--	--	--	--	--	--	--	--	--	--	--	--
Discovery/Patents & Trademarks	379	--	379	--	--	--	379	--	379	--	--	--	(379)
Plant Cost to SPD (PARC)	--	--	--	--	--	--	--	--	--	--	--	--	--
Problems 2nd Gen (Mg Chg)	--	--	--	--	--	--	--	--	--	4,728	--	4,728	4,728
Chol IV	4,297	--	4,297	--	--	--	4,297	--	4,297	4,700	--	4,700	403
MOG - Plant MOG	--	--	--	--	--	--	--	--	--	--	--	--	--
Highpurity - Plant MOG	--	--	--	--	--	--	--	--	--	--	--	--	--
Microbiome Adjustment	--	--	--	--	--	--	--	--	--	151	--	151	151
	13,815	369	14,184	--	--	--	13,815	369	14,184	13,112	834	13,946	(433)
Excess Capacity - SPD													
PPD R&D Key Concept	11,810	--	11,810	--	--	--	11,810	--	11,810	9,180	--	9,180	(2,630)
PPD R&D Response	--	--	--	--	--	--	--	--	--	--	--	--	--
Comp Key Concept	--	--	--	--	--	--	--	--	--	--	--	--	--
Mg Response	11,810	--	11,810	--	--	--	11,810	--	11,810	9,180	--	9,180	(2,630)
Excess Capacity - PPD													
Discovery	--	--	--	--	--	--	--	--	--	332	35	367	337
Drug Safety	--	--	--	--	--	--	--	--	--	834	--	834	834
Development Ops	--	--	--	--	--	--	--	--	--	35	--	35	35
Vaccine Management (Thermost)	--	--	--	--	--	--	--	--	--	--	--	--	--
Vaccine Mgmt	--	--	--	--	--	--	--	--	--	1,182	--	1,182	1,182
PARC	--	--	--	--	--	--	--	--	--	58	--	58	58
Data Management (Data overrated)	--	--	--	--	--	--	--	--	--	2,000	--	2,000	2,000
	--	--	--	--	--	--	--	--	--	2,201	1,248	3,449	4,447
Other Miscellaneous Credits													
CRO Refunds	--	--	--	(3,000)	--	(3,000)	(3,000)	--	(3,000)	--	--	--	3,000
New Settlement	--	--	--	--	--	--	--	--	--	(1,500)	--	(1,500)	(1,500)
FLAP/Response	--	--	--	--	--	--	--	--	--	(818)	--	(818)	(818)
Telomere Payments	--	--	--	--	--	--	--	--	--	2,814	--	2,814	2,814
Sampled (Cytosporus)	--	--	--	--	--	--	--	--	--	2,400	--	2,400	2,400
Metabome	--	--	--	--	--	--	--	--	--	(888)	--	(888)	(888)
Subtotal OTHER	28,770	13,528	42,298	273	1,307	1,580	27,323	14,735	42,058	43,337	18,085	61,422	19,344
Macrolide/Other													
Macrolide/Other	--	--	--	--	--	--	--	--	--	2,320	--	2,320	2,320
TOTAL "OTHER"							88,300	17,329	105,130	45,437	18,085	63,522	22,268
-- Should be input Blue Text = Input													
All Other													
Hydro	86	275	361	--	--	--	86	275	361	82	275	357	18
Macrolide AST110	--	--	--	--	--	--	--	--	--	25	--	25	25
Protein/Macrolide AST228	--	--	--	--	--	--	--	--	--	18	--	18	18
MOG AST108	5	--	5	--	--	--	5	--	5	97	--	97	92
Taxane AST271	--	--	--	--	--	--	--	--	--	14	--	14	14
FLAP AST188	22	--	22	--	--	--	22	--	22	114	--	114	92
Recombinant AST622	--	--	--	--	--	--	--	--	--	1,242	--	1,242	1,242
Discovery	--	--	--	--	--	--	--	--	--	--	--	--	--
BAET	--	--	--	--	--	--	--	--	--	--	--	--	--
PHART Metabolic Complications	--	--	--	--	--	--	--	--	--	--	--	--	--
Mac	--	--	--	--	--	--	--	--	--	--	--	--	--
Fenofibrate (Vascular)	--	--	--	--	--	--	--	--	--	88	--	88	88
Complication Initiative	--	6,087	6,087	--	--	--	--	6,087	6,087	6,279	--	6,279	192
Pharmacogenetics	--	1,701	1,701	--	--	--	--	1,701	1,701	4,841	--	4,841	2,340
Total All Other	80	8,073	8,153	--	--	--	80	8,073	8,153	1,602	18,801	12,293	4,117

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2001 PLAN Rollforward

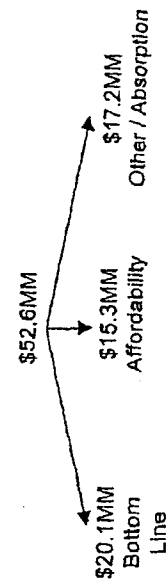
	Bottom Line	Other	Affordability
Book II			
Re-prioritization	592.1	71.5	(25.1)
Subtotal	0	9.4 A	(2.6) B
	592.1	80.9	(27.7)
Task Exercise	20.1	5.2 C	17.9 D
Final Plan	572.0	86.1	(9.8)

A Added \$12MM in grants and cut \$18.8MM in other. Projects cut (\$6.8MM) and functionals added \$2.6MM. This means absorption went up \$9.4MM.

B Functional impact was up \$12MM in grants and down (\$18.8MM / 2) = (\$9.4MM) in functionals
\$12MM - \$9.4MM = \$2.6MM

C Projects cut \$55.0MM which translated into functional cuts of \$40.3MM. \$55.0MM - \$40.3MM = \$14.7MM of unabsorption. In addition to the unabsorption, relief was given by Commercial for Gabril/Corp. Alloc for \$1.6MM, the Cyclosporine deal with SPD was terminated for an \$0.4MM, FTI #2 switch to KCO for (\$0.4MM), a change in the CMIS IDV for (\$0.4MM), elimination of Ketolide task 7.0MM, elimination of International Clarl. charges for \$3.8MM, absorption changes of (\$13.1MM) and a change in affordability of (\$8.5MM).

D Of the \$40.3MM in functional cuts, we took \$20.1MM to the bottom line, therefore \$17.9MM went to reduce affordability



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Task Backup/ Rollforwards

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2007 Plan Task Exercise
Pharmaceutical Products Division
Research and Development
(\$MM)

Project Name	Project \$MM			Functional \$MM		
	Grants	Other	Total	Grants	Other	Total
- ABSINPS	-	7.0	7.0	-	3.5	3.5
- Ketolide	-	5.0	5.0	-	2.5	2.5
- BPH	8.4	19.0	25.4	8.4	8.5	15.9
- Kaletra	(7.8)	(1.8)	(9.4)	(7.8)	(0.8)	(8.6)
- Endothelin	(10.8)	(5.8)	(16.2)	(10.8)	(2.8)	(13.4)
- KCO	0.5	5.5	6.0	0.5	2.8	3.3
- Depakote New Formulations	-	1.9	1.9	-	1.0	1.0
- K5	-	8.8	8.8	-	4.4	4.4
- Cox II	-	3.0	3.0	-	1.5	1.5
- Clarithromycin: Cystic Fibrosis Asthma International	0.7 2.4 2.0	- - -	0.7 2.4 2.0	0.7 2.4 2.0	- - -	0.7 2.4 2.0
- Tricor - Diabetics	-	4.0	4.0	-	2.0	2.0
- ChCM	1.8	5.4	7.0	1.8	2.7	4.3
- Discovery	-	5.0	5.0	-	5.0	5.0
- IM&T	-	-	-	-	1.0	1.0
- Project Expense	-	-	-	-	1.0	1.0
Total Task	(4.8)	57.4	52.6	(4.8)	33.2	28.4

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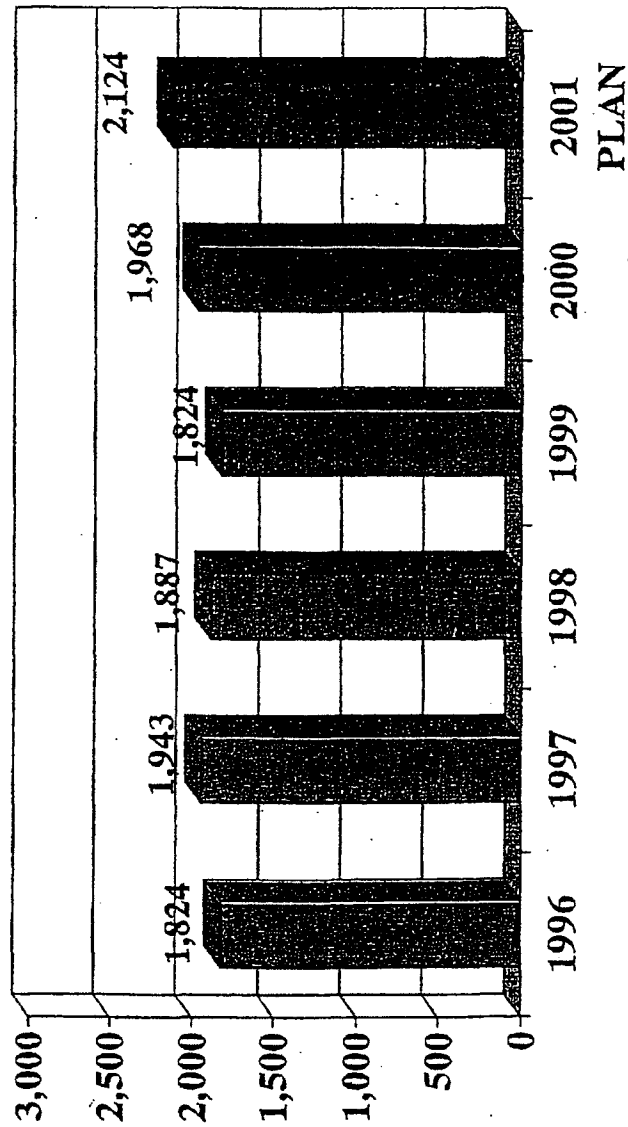
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Headcount

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R&D Regular Headcount 1996-2001



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R&D PERSONNEL - 2001 PLAN													
DEC Actual	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	12-Mo Avg
REGULAR													
GROSS	1,988	2,180	2,170	2,175	2,167	2,162	2,146	2,145	2,153	2,181	2,178	2,174	2,194
UNFILL	---	(193)	(168)	(143)	(118)	(88)	(40)	(35)	(50)	(53)	(53)	(43)	(70)
NET	2,069	1,987	2,002	2,032	2,049	2,094	2,106	2,110	2,103	2,118	2,125	2,131	2,124
TEMPORARY													
GROSS	13	21	21	21	21	34	56	56	50	22	22	22	22
UNFILL	---	---	---	---	---	---	---	---	---	---	---	---	---
NET	13	21	21	21	21	34	56	56	50	22	22	22	22
CONTRACT													
GROSS	67	80	78	79	76	78	76	77	73	74	73	75	75
UNFILL	---	---	---	---	---	---	---	---	---	---	---	---	---
NET	67	80	78	79	76	78	76	77	73	74	73	75	75
SCIENTIFIC													
GROSS	296	162	174	168	178	169	165	165	167	166	170	172	152
UNFILL	---	---	---	---	---	---	---	---	---	---	---	---	---
NET	296	162	174	168	178	169	165	165	167	166	170	172	152
TOTAL EQUIV													
GROSS	386	263	273	268	276	281	297	298	290	262	265	269	249
UNFILL	---	---	---	---	---	---	---	---	---	---	---	---	---
NET	386	263	273	268	276	281	297	298	290	262	265	269	249
GRAND TOTAL													
GROSS	2,364	2,443	2,443	2,443	2,443	2,443	2,443	2,443	2,443	2,443	2,443	2,443	2,443
UNFILL	---	(193)	(168)	(143)	(118)	(88)	(40)	(35)	(50)	(53)	(53)	(43)	(70)
NET	2,364	2,250	2,275	2,300	2,325	2,375	2,403	2,408	2,393	2,390	2,390	2,400	2,373
Div Contract													
	383	242	252	247	255	247	241	242	240	240	243	247	227

Monthly Changes												Total
J	F	M	A	M	J	J	A	S	O	N	D	
2,364	2,250	2,275	2,300	2,325	2,375	2,403	2,408	2,393	2,390	2,390	2,400	2,373
(193)	(168)	(143)	(118)	(88)	(40)	(35)	(50)	(53)	(53)	(43)	(70)	
2,364	2,250	2,275	2,300	2,325	2,375	2,403	2,408	2,393	2,390	2,390	2,400	2,373

	Quarterly Changes					End
	I	II	III	IV		
2001 PLAN	2,364	(64)	103	(23)	(7)	2,373
2000 ACTUALS	2,308	(78)	17	(15)	132	2,364
1999 ACTUALS	2,457	(311)	31	44	67	2,308
1998 ACTUALS	2,535	(90)	13	(71)	70	2,457
1997 ACTUALS	2,532	(239)	44	88	110	2,535

Total Adds	
Regular	1,988
Equivalent	1,988
Units	1,988

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Pharmaceutical Products Research & Development
2001 Plan Headcount (Mar/month) Summary

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	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total Man Months
Information Management & Technology													
Regular	177	179	180	180	181	183	186	186	189	189	189	191	2,216
Temp/Summer	---	---	---	---	---	---	---	---	---	---	---	---	---
Contractors	---	---	---	---	---	---	---	---	---	---	---	---	---
Sci/Pro	78	79	74	72	72	72	71	71	70	69	67	66	861
Net Total	255	258	254	252	253	255	257	257	259	258	256	257	3,071
Unfills	---	---	---	---	---	---	---	---	---	---	---	---	---
Gross Total	255	258	254	252	253	255	257	257	259	258	256	257	3,071
Ventures													
Regular	138	140	140	143	146	147	147	147	147	147	147	147	1,736
Temp/Summer	3	3	3	3	3	3	3	3	3	3	3	3	36
Contractors	6	6	6	6	6	6	6	5	5	5	5	5	67
Sci/Pro	16	16	16	16	16	16	16	14	14	14	14	14	182
Net Total	163	165	165	168	171	172	172	169	169	169	169	169	2,021
Unfills	11	11	11	9	6	5	5	2	2	2	2	2	68
Gross Total	174	176	176	177	177	177	177	171	171	171	171	171	2,089
Discovery													
Regular	747	745	746	746	747	748	748	748	748	748	748	749	8,968
Temp/Summer	2	4	4	4	16	23	23	17	4	3	3	3	106
Contractors	20	20	20	19	19	19	18	17	17	17	17	17	220
Sci/Pro	1	1	1	1	1	1	1	1	1	1	1	1	12
Net Total	770	770	771	770	783	791	790	783	770	769	769	770	9,306
Unfills	33	33	32	33	32	31	31	33	33	34	34	33	392
Gross Total	803	803	803	803	815	822	821	816	803	803	803	803	9,698
Drug Safety													
Regular	179	180	184	184	184	184	184	184	184	184	184	184	2,199
Temp/Summer	---	---	---	---	---	13	13	13	---	---	---	---	39
Contractors	5	5	5	5	5	5	5	5	5	5	5	5	60
Sci/Pro	---	---	---	---	---	---	---	---	---	---	---	---	---
Net Total	184	185	189	189	189	202	202	202	189	189	189	189	2,298
Unfills	21	20	16	16	16	16	16	16	16	16	16	16	201
Gross Total	205	205	205	205	205	218	218	218	205	205	205	205	2,499
Pharm Analytical R&D													
Regular	318	318	318	318	318	318	318	318	318	318	318	318	3,816
Temp/Summer	2	2	2	2	2	2	2	2	2	2	2	2	24
Contractors	17	17	17	17	17	17	17	17	17	17	17	17	204
Sci/Pro	---	---	---	---	---	---	---	---	---	---	---	---	---
Net Total	337	337	337	337	337	337	337	337	337	337	337	337	4,044
Unfills	22	22	22	22	22	22	22	22	22	22	22	22	264
Gross Total	359	359	359	359	359	359	359	359	359	359	359	359	4,308
Phase-I Center													
Regular	48	49	50	53	53	53	53	53	53	53	53	53	624
Temp/Summer	2	2	2	2	2	4	4	4	4	2	2	2	32
Contractors	8	8	7	7	7	7	7	7	7	7	7	7	86
Sci/Pro	---	---	---	---	---	---	---	---	---	---	---	---	---
Net Total	58	59	59	62	62	64	64	64	64	62	62	62	742
Unfills	1	3	3	---	---	---	---	---	---	---	---	---	7
Gross Total	59	62	62	62	62	64	64	64	64	62	62	62	749

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Pharmaceutical Products Research & Development
2001 Plan Headcount (Manmonth) Summary

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	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total Man Months
Development Operations													
Regular	148	148	148	148	148	150	150	150	150	150	150	150	1,790
Temp/Summer	1	1	1	1	1	1	1	1	1	1	1	1	12
Contractors	8	8	8	8	8	8	8	8	8	8	8	8	96
Sci/Pro	22	22	22	22	22	22	22	22	22	22	22	22	264
Net Total	179	179	179	179	179	181	181	181	181	181	181	181	2,162
Unfills	7	7	7	7	7	5	5	5	5	5	5	5	70
Gross Total	186	186	186	186	186	186	186	186	186	186	186	186	2,232
Regulatory Affairs													
Regular	57	58	60	62	62	62	62	62	62	62	62	62	733
Temp/Summer	1	1	1	1	1	1	1	1	1	1	1	1	12
Contractors	4	4	4	4	4	4	4	4	4	4	4	4	48
Sci/Pro	1	1	1	1	1	1	1	1	1	1	1	1	12
Net Total	63	64	66	68	68	68	68	68	68	68	68	68	805
Unfills	2	1	...	...	...	...	...	...	...	...	...	...	3
Gross Total	65	65	66	68	68	68	68	68	68	68	68	68	808
Medical Affairs													
Regular	112	115	119	122	122	124	125	125	125	125	125	125	1,464
Temp/Summer	1	1	3	3	3	5	5	5	1	1	1	1	30
Contractors	7	7	7	7	7	7	7	7	7	7	7	7	84
Sci/Pro	5	6	6	6	6	5	4	4	4	4	4	4	58
Net Total	125	129	135	138	138	141	141	141	137	137	137	137	1,636
Unfills	17	13	10	9	9	9	9	9	9	9	9	9	121
Gross Total	142	142	145	147	147	150	150	150	146	146	146	146	1,757
Administration													
Regular	88	88	88	88	88	88	88	88	88	88	88	88	1,056
Temp/Summer	2	2	2	2	2	2	2	2	2	2	2	2	24
Contractors	5	3	5	3	5	3	5	3	4	3	5	5	49
Sci/Pro	18	18	18	18	18	18	18	18	18	18	18	18	216
Net Total	113	111	113	111	113	111	113	111	112	111	113	113	1,345
Unfills	...	...	...	...	...	...	...	...	...	...	...	...	...
Gross Total	113	111	113	111	113	111	113	111	112	111	113	113	1,345
Judgment													
Regular	(25)	(18)	(1)	5	45	49	49	42	54	61	67	57	385
Temp/Summer	7	5	3	3	4	2	2	2	4	7	7	7	53
Contractors	...	...	...	...	...	...	...	...	...	...	...	...	...
Sci/Pro	21	31	30	43	33	30	32	36	36	41	45	26	404
Net Total	3	18	32	51	82	81	83	80	94	109	119	90	842
Unfills	79	58	42	22	(24)	(48)	(53)	(37)	(24)	(35)	(45)	(17)	(82)
Gross Total	82	76	74	73	58	33	30	43	70	74	74	73	924
Total Plan Detail													
Regular	1,987	2,002	2,032	2,049	2,094	2,106	2,110	2,103	2,118	2,125	2,131	2,124	24,981
Temp/Summer	21	21	21	21	34	56	56	50	22	22	22	22	368
Contractors	80	78	79	76	78	76	77	73	74	73	75	75	914
Sci/Pro	162	174	188	179	189	185	185	167	186	170	172	152	2,009
Net Total	2,250	2,275	2,300	2,325	2,375	2,403	2,408	2,393	2,380	2,390	2,400	2,373	28,272
Unfills	193	168	143	118	68	40	35	50	63	53	43	70	1,044
Gross Total	2,443	2,443	2,443	2,443	2,443	2,443	2,443	2,443	2,443	2,443	2,443	2,443	29,316

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Pharmaceutical Products Research & Development
2001 Plan Headcount (Manmonth) Summary

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	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total Man Months
From Heads Tab													
Regular	1,987	2,002	2,032	2,049	2,094	2,106	2,110	2,103	2,118	2,125	2,131	2,124	24,981
Temporary/Summ	21	21	21	21	34	56	56	50	22	22	22	22	368
Contractors	85	83	85	85	85	84	86	84	85	84	85	85	1,016
Sci/Pro	157	169	162	170	162	157	156	156	155	159	162	142	1,907
Total	2,250	2,275	2,300	2,325	2,375	2,403	2,408	2,393	2,380	2,390	2,400	2,373	28,272
Unfills	193	168	143	118	68	40	35	50	63	53	43	70	1,044
Total	2,443	2,443	2,443	2,443	2,443	2,443	2,443	2,443	2,443	2,443	2,443	2,443	29,316
Detail > Corp Submission													
Regular	---	---	---	---	---	---	---	---	---	---	---	---	---
Temporary/Summ	---	---	---	---	---	---	---	---	---	---	---	---	---
Contractors/Sci Pr	---	---	---	---	---	---	---	---	---	---	---	---	---
Total	---	---	---	---	---	---	---	---	---	---	---	---	---
Unfills	---	---	---	---	---	---	---	---	---	---	---	---	---
Total	---	---	---	---	---	---	---	---	---	---	---	---	---
2001 Corp Submission													
Regular	1,987	2,002	2,032	2,049	2,094	2,106	2,110	2,103	2,118	2,125	2,131	2,124	24,981
Temporary/Summ	21	21	21	21	34	56	56	50	22	22	22	22	368
Contractors/Sci Pr	242	252	247	255	247	241	242	240	240	243	247	227	2,923
Total	2,250	2,275	2,300	2,325	2,375	2,403	2,408	2,393	2,380	2,390	2,400	2,373	28,272
Unfills	193	168	143	118	68	40	35	50	63	53	43	70	1,044
Total	2,443	2,443	2,443	2,443	2,443	2,443	2,443	2,443	2,443	2,443	2,443	2,443	29,316

Oracle Report 01/31/01

Regular	2,012	2,020	2,033	2,051	2,049	2,057	2,069	2,061	2,061	2,064	2,064	2,057	24,608
Temporary/Summ	14	16	18	18	30	54	54	54	48	18	15	15	354
Contractors	80	78	79	76	78	76	77	77	73	74	75	75	918
Sci/Pro	141	143	138	135	136	135	133	133	131	130	127	126	1,608
Total	2,247	2,257	2,268	2,280	2,293	2,322	2,333	2,325	2,313	2,286	2,281	2,283	27,488
Unfills	114	110	101	89	92	88	79	88	87	87	88	87	1,110
Total	2,361	2,367	2,369	2,369	2,385	2,410	2,412	2,413	2,400	2,373	2,369	2,370	28,598

Check figure Oracle vs details before judgement

Regular	---	---	---	7	---	---	8	---	(3)	---	---	---	12
Temporary/Summ	---	---	---	---	---	---	---	6	30	3	---	---	39
Contractors	---	---	---	---	---	---	---	4	(1)	1	---	---	4
Sci/Pro	---	---	---	(1)	---	---	---	2	1	1	---	---	3
Total	---	---	---	6	---	---	8	12	27	5	---	---	58
Unfills	---	---	---	(7)	---	---	(9)	1	---	(1)	---	---	(16)
Total	---	---	---	(1)	---	---	(1)	13	27	4	---	---	42

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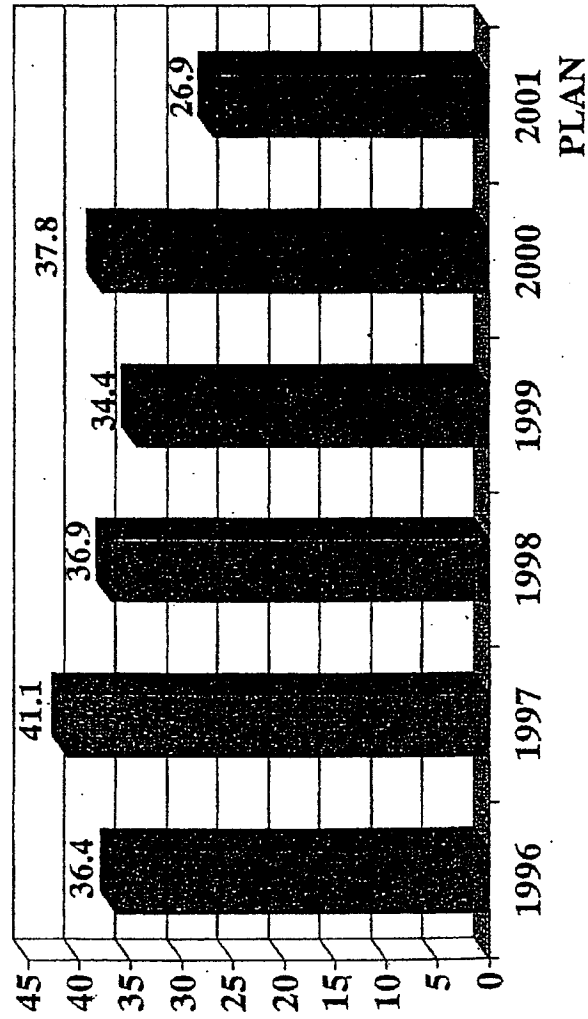
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Capital

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R&D Capital 1996-2001 (\$MM's)



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Final Plan

**2001 PLAN Capital
Pharmaceutical Products Research & Development**

	2000 AGU	2001 PLAN	\$ Fav/(Unfav)	% Fav/(Unfav)
Authorizations				
IM&T	6,672	4,748	1,924	28.8%
Discovery	11,268	7,628	3,642	32.3%
Drug Safety	3,620	3,125	395	11.2%
PARD	3,485	5,805	(2,320)	-66.8%
Admin	12,380	3,490	8,890	71.9%
Dev Ops	100	100	0	0.0%
Medical Affairs	50	50	0	0.0%
RA/QA	10	10	0	0.0%
Other	283	2,000	(1,717)	-608.7%
Total	37,778	26,944	10,834	28.7%

Project Expense				
IM&T	8,631	2,090	6,541	75.8%
Discovery	1,095	892	203	18.6%
Drug Safety	272	17	255	93.8%
PARD	425	828	(403)	-94.8%
Admin	1,498	743	755	50.4%
Dev Ops	8	9	0	0.0%
Medical Affairs	11	11	0	0.0%
RA/QA	4	4	0	0.0%
Other	4	0	4	100.0%
Judgment	(1,722)	400	(2,122)	123.2%
Total	10,228	4,984	5,234	51.2%

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**PHARMACEUTICAL PRODUCTS DIVISION
RESEARCH & DEVELOPMENT
PROPOSED CAPITAL PROJECTS <\$250M**

	2000 AGU	2001 Authorizations		01 Funded v. '00 AGU
		Requests	Funded Unfunded	
IM&T *	3,196	3,787	2,538 1,249	658
Development Ops	100	100	100 0	0
Discovery	4,670	4,027	4,027 0	643
Drug Safety	2,050	2,809	2,050 759	0
PARD	2,455	3,092	2,455 637	0
Medical Affairs	50	45	50 (5)	0
RA/QA	10	20	10 10	0
Other	283	0	2,000 (2,000)	(1,717)
Total	12,814	13,880	13,230 650	(416)

* Includes \$1,545M for PC refresh and new employees.

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2001 Plan Task Exercises Pharmaceutical Products Division Research and Development			
Capital Projects (\$MM)			
Project Name	Capital Auth	Project Exp	Commentary
Admin:			
- Delay AEGIS Wave III to 2002	2,000	-	
- Reduce lab renovations	2,000	400	
Subtotal Admin	4,000	400	
IM&T:			
- Reduce PC Refresh / Asset Mgmt	400	-	
- RT Storage Mgmt	884	164	
- Under \$250 project expense reduced	-	412	
Subtotal IM&T	1,084	596	
Discovery:			
- Therapeutic Area Projects Support	186	1,882	
- HTS Expansion	1,030	300	
- Genomics Expansion	880	480	
- Bring under \$250 back to original request amount	843	-	
- Under \$250 project expense reduced	-	200	
Subtotal Discovery	2,401	2,862	
Drug Safety:			
- LCMS	1,910	120	
- Lab Renovation API 3A	-	-	
- Gene Expression	411	1,044	
- Under \$250 project expense reduced	-	-	
Subtotal Drug Safety	2,321	1,164	
PASD:			
- Potent Drug Encapsulator	600	100	
- Under \$250 project expense reduced	-	400	
Subtotal PASD	600	500	
Other:			
- Eliminate Judgment	283	478	
- Unidentified Reverse Task	(2,000)	(400)	
Total Impact	8,559	5,000	

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Capital Authorizations		Proj Expense	
> 250	< 250	> 250	< 250
IM&T	2,810	2,836	4,748
Discovery	3,698	4,027	7,028
Drug Safety	1,078	2,050	3,125
PASD	3,350	2,455	6,805
Admin	3,480	-	3,480
Dev Ops	-	100	100
Med Affairs	-	60	80
RA/DA	-	10	10
Other	-	2,000	2,000
Total	13,714	13,230	28,944

-Pharmacology Labs & APB/G19 Renovations

Assume 4 year refresh vs. 3 year
Pending IM&T's approval. There is \$977 of functional expense associated with this project.Listed as an IM&T project in capital file. There is \$544 of functional expense associated with this project.
Pending D. Norbeck's approval
Pending D. Norbeck's approval
Pending D. Norbeck's approval
Pending D. Norbeck's approval

Balance Sheet

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Pharmaceutical Products Division
DETAIL OF PREPAID EXP. AND OTHER RECEIVABLES

BOOK 11 607

Category	Actual 12/31/07	Actual 12/31/08	Actual 12/31/09	Actual 12/31/10	AGU	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	12 MO AVG
SALARIES, WAGES & COMMISSIONS																		
Mgmt Incentive plans - R&D	(2,360)	(2,390)	(4,051)	(3,822)		(3,272)	(3,524)	(64)	(1,005)	(1,269)	(1,610)	(1,183)	(2,014)	(2,269)	(2,816)	(2,710)	(3,022)	(2,440)
OTHER ACCRUED LIABILITIES																		
Clinical grants - R&D	(78,837)	(87,960)	(84,947)	(84,780)		(66,180)	(82,236)	(84,126)	(82,137)	(81,651)	(81,601)	(83,119)	(49,489)	(48,131)	(42,829)	(44,717)	(43,761)	(42,294)
Drug Safety Grant Accrual - R&D	(489)	(668)	(672)	(654)		(890)	(590)	(886)	(886)	(886)	(886)	(886)	(886)	(886)	(886)	(886)	(886)	(891)
Misc R&D	(8,821)	(8,511)	(6,742)	(9,007)		(11,102)	(10,037)	(10,360)	(9,381)	(11,037)	(10,043)	(11,230)	(12,794)	(10,161)	(13,071)	(11,321)	(7,878)	(10,288)
OTHER ACCRUED LIABILITIES																		
	(58,247)	(53,245)	(46,352)	(64,337)		(69,638)	(72,578)	(76,104)	(72,774)	(73,284)	(72,150)	(63,721)	(82,618)	(59,879)	(87,483)	(59,824)	(51,222)	(64,189)
TOTAL A/P & ACCRUED EXP.	(88,207)	(94,481)	(149,353)	(147,279)		(73,110)	(78,403)	(78,868)	(73,779)	(74,823)	(73,660)	(67,483)	(84,132)	(59,144)	(80,000)	(59,814)	(54,942)	(69,809)

Pharmaceutical Products Division
DETAIL OF PREPAID EXP. AND OTHER RECEIVABLES

Category	Actual 12/31/07	Actual 12/31/08	Actual 12/31/09	Actual 12/31/10	AGU	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	12 MO AVG
PREPAID EXPENSE																		
Sponsorship plans (R&D)	464	414	438	422		432	432	432	432	432	432	432	432	432	432	432	432	432
Ligand Contract	0	0	0	0		0	0	0	0	0	0	0	0	0	0	0	0	0
Toxigenic Reserve	0	0	0	0		0	0	0	0	0	0	0	0	0	0	0	0	0
Clinical R&D	0	0	0	0		0	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL PREPAID EXPENSE	464	414	438	422		432	432	432	432	432	432	432	432	432	432	432	432	432
OTHER RECEIVABLES																		
Travel advances (R&D)	873	302	170	328		876	876	876	876	876	876	876	876	876	876	876	876	809
TOTAL PREPAID AND OTHER RECEIVABLE	1,057	716	608	750		1,008	1,008	1,008	1,008	1,008	1,008	1,008	1,008	1,008	1,008	1,008	1,008	1,008

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FINANCIAL GRANT BALANCE SHEET GAITING
 PRD 348-300
 101 PLAN

	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Total
Beginning G/L Balance	(53,000)	(58,150)	(62,256)	(64,128)	(62,837)	(61,651)	(61,501)	(53,815)	(49,488)	(46,131)	(43,825)	(44,717)	
Payments	8,946	8,867	11,077	11,788	11,421	10,547	12,283	8,231	9,461	9,393	8,781	10,754	122,556
Allocated Grants (per P&L gaiting)	(14,095)	(12,873)	(12,948)	(10,508)	(10,235)	(10,387)	(4,587)	(4,894)	(9,124)	(7,087)	(9,673)	(9,788)	(113,317)
Grant Gaiting Adjustments													
Adjusted Grants	(14,095)	(12,873)	(12,948)	(10,508)	(10,235)	(10,387)	(4,587)	(4,894)	(9,124)	(7,087)	(9,673)	(9,788)	(113,317)
Other	...	...	...	...	...	...	...	...	...	...	...	...	...
Ending G/L Balance	(58,150)	(62,256)	(64,128)	(62,837)	(61,651)	(61,501)	(53,815)	(49,488)	(46,131)	(43,825)	(44,717)	(43,781)	
Indposings :													
Debit Balances	...	...	...	...	...	...	...	...	...	...	...	...	...
Other	...	...	...	...	...	...	...	...	...	...	...	...	...
Ending MFRP Balance	(58,150)	(62,256)	(64,128)	(62,837)	(61,651)	(61,501)	(53,815)	(49,488)	(46,131)	(43,825)	(44,717)	(43,781)	
28-Sep-00 02:07 PM													
3 GROUP PLAN INQ 0001 PLAN Balance Sheet (Bal_sht_xls) Grants													
96 Actual Pay as % of BB	22.25%	19.15%	30.88%	15.59%	20.20%	10.84%	25.05%	18.13%	20.28%	13.89%	21.78%	22.13%	
97 Actual Pay as % of BB	12.28%	6.82%	10.12%	14.89%	22.48%	11.49%	11.21%	12.60%	7.44%	9.08%	8.81%	14.55%	
98 Actual Pay as % of BB	3.62%	7.21%	5.93%	7.71%	9.64%	10.15%	9.46%	5.76%	8.98%	11.16%	8.68%	16.24%	
99 Actual Pay as % of BB	10.49%	10.81%	8.18%	19.70%	4.49%	18.73%	17.90%	12.52%	18.69%	25.64%	18.05%	20.81%	
Our year average	12.16%	10.85%	13.78%	14.50%	14.20%	13.05%	15.91%	12.61%	14.07%	14.84%	14.33%	18.48%	
96 Actual	18,915	25,781	25,749	26,740	25,881	31,230	29,251	27,202	25,939	25,579	24,839	24,988	
97 Actual	40,698	46,087	49,433	46,762	44,188	47,690	50,516	55,955	62,781	64,408	67,079	75,827	
98 Actual	78,671	78,485	79,324	78,977	75,387	70,808	69,331	66,581	65,681	66,718	62,780	60,600	
99 Actual	57,702	57,392	58,501	51,012	49,787	47,310	39,852	33,259	34,582	36,331	40,172	43,840	
Our year average	48,997	51,938	53,252	51,370	48,808	46,235	47,237	45,749	47,238	46,258	46,720	51,284	

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Depreciation

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Pharmaceutical Products Division R&D
2001 Depreciation Estimate vs. 2000 Depreciation
By Division

Division	2001 Est. Base Depr.	2001 Estimated Depr. of Projects from 5/00-12/00	2001 Estimated Depr. for '01 Transfer	Judgement	2001 Est. Total Depr.	2000 Depreciation	\$ Inc/(Dec)	% Inc/(Dec)
42-IM&T	4,385	1,056	285	(134)	5,592	6,253	(661)	-10.8%
43-Ventures	293	24	8	(5)	319	276	43	15.6%
44-Discovery	11,103	1,758	688	(383)	13,165	12,806	259	2.0%
46-Drug Safety	2,703	23	482	(258)	2,950	3,048	(98)	-3.2%
47-PARD	3,721	235	270	(208)	4,020	4,428	(408)	-9.2%
49-Phase I Center	244	2	9	(7)	248	205	43	21.0%
52-Development Ops.	1,535	1	10	(8)	1,638	1,405	133	9.5%
53-RA/QA	90	6	4	(4)	98	68	30	44.1%
54-Medical Affairs	208	8	8	(8)	220	182	38	20.9%
56-Admin	448	2,699	43	(33)	3,157	2,031	1,126	55.4%
	<u>24,730</u>	<u>5,813</u>	<u>1,808</u>	<u>(1,043)</u>	<u>31,307</u>	<u>30,800</u>	<u>507</u>	<u>1.7%</u>

* Based on the FAR 50 Report dated 5/00.

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Floorspace

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**PPD R&D
FLOOR SPACE SUMMARY
2001 PLAN**

Items	2000	1st Pass 2001	2nd Pass 2001	1st Pass		2nd Pass	
				VARIANCE INCR/(DECR)	%	VARIANCE INCR/(DECR)	%
CED	36,807,916	38,691,048	38,777,828 ¹	1,883,132	5.1%	1,969,910	5.4%
J23/J25- Amhurst	457,449	480,322	464,991 ²	22,872	5.0%	7,542	1.6%
J35 -Carriage pt	351,680	369,264	343,468 ⁴	17,584	5.0%	(6,214)	(2.3%)
J28/MIS	408,769	429,207	406,341 ³	20,438	5.0%	(2,428)	(0.6%)
Unidentified Space	40,056	42,061	41,860	2,003	n/a	1,802	n/a
Plug (w/b zero)	0	0	0	0	0.0%	0	0.0%
TOTAL	40,056	42,061	41,860	2,003	0.0%	0	0.0%

¹ Input per CED Report, Pass #1 dated 9/29/00 and CED Report Pass #2 dated 9/1/00 plus the adjustment for D-472. This adjustment was detailed in John Uhl's memo dated 1/29/2001. The adjustment equals \$21,424 for additional space in D-472 as requested by J. Hammerlin.

² Per CED Report (dated 9/1/00) and Division Summary from P. Kadish (dated 9/29/00).
Note: Amhurst rates for 2001 PLAN went up by 1.65% versus 2000 PLAN. (Sq. ft. are obtained from CED memo, while \$\$\$ are obtained from Division memo.

³ Per memo received from Sarah Schaefer on 8/21/00 per S. Schaefer 10/1/02.

⁴ Carriage Point charges to be allocated, calculated as follows:
Lease charge from Legal (R. Polocsek) of \$478,632 for 2001
Total expenses of \$716,633 allocated between Marketing and R&D based on square feet occupied.

Total lease charges	\$478,632	31,400
Less Slackcard to T. Thompson	(\$136,366)	(6,976)
Net charge to Discovery	<u>\$343,466</u>	<u>25,425</u>

CONFIDENTIAL - PPD R&D Floor Space Summary

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PPD R&D
DIVISIONAL VARIANCE SUMMARY
2001 PLAN
FLOORSPACE

Division	Total Dollars (\$00's)			Total Square Feet			Average Rate		
	2000	2001	% Inc/Dec	2000	2001	% Inc/Dec	2000	2001	% Inc/Dec
R&D	1,884.4	1,928.9	44.8	80,647	50,782	(85)	\$37.08	\$37.98	\$0.92
Ventures	1,051.3	1,016.4	(34.8)	25,028	28,878	(2,250)	\$38.34	\$38.10	\$1.78
Drug Safety	18,228.8	19,820.7	873.9	384,892	368,516	683	\$50.78	\$53.41	\$2.64
PARC	6,485.2	6,164.8	(228.4)	146,928	144,747	(1,191)	\$51.98	\$54.84	\$2.89
Phase I Center	288.9	301.2	14.4	14,685	14,588	(279)	\$40.42	\$42.97	\$2.15
Development Ops	1,441.1	1,357.7	(83.6)	4,080	0	0	\$51.17	\$42.23	\$3.08
Regulatory Affairs	434.8	484.4	29.7	38,734	33,938	(4,796)	\$37.21	\$40.00	\$2.80
Medical Affairs	559.6	678.6	119.0	12,133	12,378	240	\$35.82	\$37.92	\$1.71
Administration	443.1	702.7	259.6	17,104	18,898	1,652	\$22.52	\$36.61	\$9.08
				10,164	18,898	5,492	\$43.58	\$44.88	\$1.28
Less Carriage Point	(331.7)	(343.6)	8.2	...	...	...	N/A	N/A	N/A
							N/A	N/A	N/A

(a) Primarily due to Clinical Pharmacokinetics (D-490) receiving 1,107 sq. ft. in APG for 2001 PLAN.
 (b) Primarily due to Satellite (D-438) re-allocating their space to Outcome research (D-42); Med. Affairs and Decision Analysis (D-44); Admin.
 (c) Primarily due to R&D Ops (D-477) receiving and additional 644 sq. ft. in APG and due to Outcome Research (discussed in footnote (b) above).

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**PPD R&D
BUILDING VARIANCE SUMMARY
2001 PLAN
FLOORS/SPACE**

Building	Total Dollars (\$000's)		Total Square Feet		Average Rate	
	2000	2001	Inc(Dec)	% Inc(Dec)	2000	2001
A1	11.9	12.6	0.7	6.0%	\$31.02	\$32.68
A4	231.1	242.2	11.2	4.8%	\$38.34	\$39.10
API0	4,485.2	5,242.0	756.8	16.9%	\$46.41	\$50.59
API3	1,740.0	1,818.6	78.6	4.5%	\$46.86	\$51.06
API3A	4,489.7	4,722.8	233.1	5.2%	\$51.17	\$54.23
API6	151.0	165.4	14.4	9.5%	\$12.86	\$13.46
API6A	134.0	131.1	(3.0)	(2.2%)	\$26.46	\$25.97
AP20	183.5	172.5	(11.0)	(6.0%)	\$34.35	\$34.58
AP3	883.2	928.5	45.3	5.1%	\$34.35	\$34.58
AP30	930.2	975.2	45.0	4.8%	\$34.35	\$34.58
AP31	861.5	907.9	46.4	5.4%	\$34.35	\$34.58
AP34	237.7	268.4	30.7	12.9%	\$34.35	\$34.58
AP32	5,085.9	5,375.6	289.7	5.7%	\$34.35	\$34.58
AP6A	506.0	528.3	22.3	4.4%	\$34.35	\$34.58
AP6B	832.1	872.4	40.3	4.8%	\$34.35	\$34.58
AP6C	83.6	83.6	0.0	(100.0%)	\$34.35	\$34.58
AP6D	25.3	32.3	6.9	27.4%	\$34.35	\$34.58
AP6E	3,068.0	3,823.1	755.1	24.6%	\$34.35	\$34.58
AP6A	4,388.3	4,627.3	239.0	5.4%	\$34.35	\$34.58
AP6B	481.1	481.1	0.0	0.0%	\$34.35	\$34.58
J2	185.1	185.2	0.1	0.1%	\$34.35	\$34.58
J23 (Amhurst)	272.3	278.8	6.5	2.4%	\$34.35	\$34.58
J28 (North Point-MIS)	408.8	408.3	(0.5)	(0.1%)	\$34.35	\$34.58
J28 (Carriage Point)	351.7	343.5	(8.2)	(2.3%)	\$34.35	\$34.58
M2	28.6	30.5	1.9	6.7%	\$34.35	\$34.58
M3	611.3	637.2	25.9	4.2%	\$34.35	\$34.58
R1	168.9	161.0	(7.9)	(4.7%)	\$34.35	\$34.58
R12	353.9	369.8	15.9	4.5%	\$34.35	\$34.58
R13	2,054.3	2,063.0	8.6	0.4%	\$34.35	\$34.58
R14	876.8	937.3	60.5	6.9%	\$34.35	\$34.58
R16	1,041.3	1,219.8	178.4	17.1%	\$34.35	\$34.58
R2	331.4	357.4	26.0	7.8%	\$34.35	\$34.58
R6	839.6	873.5	33.7	4.0%	\$34.35	\$34.58
Less Carriage Point	(351.7)	(343.5)	8.2	(2.3%)	N/A	N/A

MEMO:	
CRD Rate	Increased by 5.1%
Amhurst Rate	Increased by 1.8%
North Point Charges	Decreased by 0.8%
Carriage Point Charges	Decreased by 2.3% due to commandal assuming responsibility for 800 sq. ft. more over year 2000.

- (a) Primarily due to PARD's Intermediate Scale Up facilities (D-4P2) accounting for 486 sq. ft. and \$8.6 over year 2000.
 (b) Primarily due to PARD's Intermediate Scale Up facilities (D-4P2) using less space in AP16A and more in AP18.
 (c) Due to Customer Research (D-4J) no longer needing space in AP6C.
 (d) Only due to an increased allocation on the floor plan (D-4J1). Amount will reside in D-454 until floor plan can be updated.
 (e) See Carriage Point (D-4J1) occupancy 25,426 sq. ft. in J28.
 (f) Includes change of \$41.8 for R13 (D-4J1) occupancy 25,426 sq. ft. in J28.
 (g) Primarily due to PARD's Intermediate Scale Up facilities (D-4P2) occupying more space; partially offset by PARD Process Support (D-4P3) needing less space.
 (h) Due to PARD's Pharm. Analysis & Stability occupying more space.

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Misc. Fixed Expenses (Burden File)

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PPD		Overhead Costs		Absorbed		GROSS (\$000)	
2000	2001	2001	2001	2001	2001	2001	2001
AGU	Plan	APU	AGU	AGU	AGU	AGU	AGU
1							
2							
3							
4							
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1	Subtotal Corp Admin Assign-In	10,359.9	11,495.3	11,495.3	11,495.3		
2	Corp Other Costs (In Departments)	5,730.0	5,809.3	5,809.3	5,809.3		
3	Change to Department	0.0	0.0	0.0	0.0		
4	Change to Department	0.0	0.0	0.0	0.0		
5	Change to Department	0.0	0.0	0.0	0.0		
6	Change to Department	0.0	0.0	0.0	0.0		
7	Change to Department	0.0	0.0	0.0	0.0		
8	Change to Department	0.0	0.0	0.0	0.0		
9	Change to Department	0.0	0.0	0.0	0.0		
10	Change to Department	0.0	0.0	0.0	0.0		
11	Change to Department	0.0	0.0	0.0	0.0		
12	Change to Department	0.0	0.0	0.0	0.0		
13	Change to Department	0.0	0.0	0.0	0.0		
14	Change to Department	0.0	0.0	0.0	0.0		
15	Change to Department	0.0	0.0	0.0	0.0		
16	Change to Department	0.0	0.0	0.0	0.0		
17	Change to Department	0.0	0.0	0.0	0.0		
18	Change to Department	0.0	0.0	0.0	0.0		
19	Change to Department	0.0	0.0	0.0	0.0		
20	Change to Department	0.0	0.0	0.0	0.0		
21	Change to Department	0.0	0.0	0.0	0.0		
22	Change to Department	0.0	0.0	0.0	0.0		
23	Change to Department	0.0	0.0	0.0	0.0		
24	Change to Department	0.0	0.0	0.0	0.0		
25	Change to Department	0.0	0.0	0.0	0.0		
26	Change to Department	0.0	0.0	0.0	0.0		
27	Change to Department	0.0	0.0	0.0	0.0		
28	Change to Department	0.0	0.0	0.0	0.0		
29	Change to Department	0.0	0.0	0.0	0.0		
30	Change to Department	0.0	0.0	0.0	0.0		
31	Change to Department	0.0	0.0	0.0	0.0		
32	Change to Department	0.0	0.0	0.0	0.0		
33	Change to Department	0.0	0.0	0.0	0.0		
34	Change to Department	0.0	0.0	0.0	0.0		
35	Change to Department	0.0	0.0	0.0	0.0		
36	Change to Department	0.0	0.0	0.0	0.0		
37	Change to Department	0.0	0.0	0.0	0.0		
38	Change to Department	0.0	0.0	0.0	0.0		
39	Change to Department	0.0	0.0	0.0	0.0		
40	Change to Department	0.0	0.0	0.0	0.0		
41	Change to Department	0.0	0.0	0.0	0.0		
42	Change to Department	0.0	0.0	0.0	0.0		
43	Change to Department	0.0	0.0	0.0	0.0		
44	Change to Department	0.0	0.0	0.0	0.0		
45	Change to Department	0.0	0.0	0.0	0.0		
46	Change to Department	0.0	0.0	0.0	0.0		
47	Change to Department	0.0	0.0	0.0	0.0		
48	Change to Department	0.0	0.0	0.0	0.0		
49	Change to Department	0.0	0.0	0.0	0.0		
50	Change to Department	0.0	0.0	0.0	0.0		
51	Change to Department	0.0	0.0	0.0	0.0		
52	Change to Department	0.0	0.0	0.0	0.0		
53	Change to Department	0.0	0.0	0.0	0.0		
54	Change to Department	0.0	0.0	0.0	0.0		
55	Change to Department	0.0	0.0	0.0	0.0		
56	Change to Department	0.0	0.0	0.0	0.0		
57	Change to Department	0.0	0.0	0.0	0.0		
58	Change to Department	0.0	0.0	0.0	0.0		
59	Change to Department	0.0	0.0	0.0	0.0		
60	Change to Department	0.0	0.0	0.0	0.0		
61	Change to Department	0.0	0.0	0.0	0.0		
62	Change to Department	0.0	0.0	0.0	0.0		
63	Change to Department	0.0	0.0	0.0	0.0		
64	Change to Department	0.0	0.0	0.0	0.0		
65	Change to Department	0.0	0.0	0.0	0.0		
66	Change to Department	0.0	0.0	0.0	0.0		
67	Change to Department	0.0	0.0	0.0	0.0		
68	Change to Department	0.0	0.0	0.0	0.0		
69	Change to Department	0.0	0.0	0.0	0.0		
70	Change to Department	0.0	0.0	0.0	0.0		
71	Change to Department	0.0	0.0	0.0	0.0		
72	Change to Department	0.0	0.0	0.0	0.0		
73	Change to Department	0.0	0.0	0.0	0.0		
74	Change to Department	0.0	0.0	0.0	0.0		
75	Change to Department	0.0	0.0	0.0	0.0		
76	Change to Department	0.0	0.0	0.0	0.0		
77	Change to Department	0.0	0.0	0.0	0.0		
78	Change to Department	0.0	0.0	0.0	0.0		
79	Change to Department	0.0	0.0	0.0	0.0		
80	Change to Department	0.0	0.0	0.0	0.0		
81	Change to Department	0.0	0.0	0.0	0.0		
82	Change to Department	0.0	0.0	0.0	0.0		
83	Change to Department	0.0	0.0	0.0	0.0		
84	Change to Department	0.0	0.0	0.0	0.0		
85	Change to Department	0.0	0.0	0.0	0.0		
86	Change to Department	0.0	0.0	0.0	0.0		
87	Change to Department	0.0	0.0	0.0	0.0		
88	Change to Department	0.0	0.0	0.0	0.0		
89	Change to Department	0.0	0.0	0.0	0.0		
90	Change to Department	0.0	0.0	0.0	0.0		
91	Change to Department	0.0	0.0	0.0	0.0		
92	Change to Department	0.0	0.0	0.0	0.0		
93	Change to Department	0.0	0.0	0.0	0.0		
94	Change to Department	0.0	0.0	0.0	0.0		
95	Change to Department	0.0	0.0	0.0	0.0		
96	Change to Department	0.0	0.0	0.0	0.0		
97	Change to Department	0.0	0.0	0.0	0.0		
98	Change to Department	0.0	0.0	0.0	0.0		
99	Change to Department	0.0	0.0	0.0	0.0		
100	Change to Department	0.0	0.0	0.0	0.0		

1	LC Skills Develop	4	4	4	4		
2	LC Emp Skills Train College Relations	0.0	0.0	0.0	0.0		
3	DBS Headcount Support	443.1	514.3	514.3	514.3		
4	DOSSA Tullion	148.0	144.0	144.0	144.0		
5	Human Resources Recruiting	1,853.9	1,838.5	1,838.5	1,838.5		
6	Change to Department	0.0	0.0	0.0	0.0		
7	Change to Department	0.0	0.0	0.0	0.0		
8	Change to Department	0.0	0.0	0.0	0.0		
9	Change to Department	0.0	0.0	0.0	0.0		
10	Change to Department	0.0	0.0	0.0	0.0		
11	Change to Department	0.0	0.0	0.0	0.0		
12	Change to Department	0.0	0.0	0.0	0.0		
13	Change to Department	0.0	0.0	0.0	0.0		
14	Change to Department	0.0	0.0	0.0	0.0		
15	Change to Department	0.0	0.0	0.0	0.0		
16	Change to Department	0.0	0.0	0.0	0.0		
17	Change to Department	0.0	0.0	0.0	0.0		
18	Change to Department	0.0	0.0	0.0	0.0		
19	Change to Department	0.0	0.0	0.0	0.0		
20	Change to Department	0.0	0.0	0.0	0.0		
21	Change to Department	0.0	0.0	0.0	0.0		
22	Change to Department	0.0	0.0	0.0	0.0		
23	Change to Department	0.0	0.0	0.0	0.0		
24	Change to Department	0.0	0.0	0.0	0.0		
25	Change to Department	0.0	0.0	0.0	0.0		
26	Change to Department	0.0	0.0	0.0	0.0		
27	Change to Department	0.0	0.0	0.0	0.0		
28	Change to Department	0.0	0.0	0.0	0.0		
29	Change to Department	0.0	0.0	0.0	0.0		
30	Change to Department	0.0	0.0	0.0	0.0		
31	Change to Department	0.0	0.0	0.0	0.0		
32	Change to Department	0.0	0.0	0.0	0.0		
33	Change to Department	0.0	0.0	0.0	0.0		
34	Change to Department	0.0	0.0	0.0	0.0		
35	Change to Department	0.0	0.0	0.0	0.0		
36	Change to Department	0.0	0.0	0.0	0.0		
37	Change to Department	0.0	0.0	0.0	0.0		
38	Change to Department	0.0	0.0	0.0	0.0		
39	Change to Department	0.0	0.0	0.0	0.0		
40	Change to Department	0.0	0.0	0.0			

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PPD R&D
2001 Fixed Allocations/Charges
GROSS (\$000)

Direct to Departments (Stack Card)	2000 AGU	2001 Plan	2001 APU	2001 AGU	01 Plan I/(D) vs. '00 AGU		Notes
					\$	%	
PPNC Allocations							
11 Wisdom to Product Development and RAQ	328.7	322.7	322.7	322.7	-6.0	-1.8%	PPD Ops Fixed (T. Dee / J. Truax)
12 Other to Product Development	2,031.0	3,044.8	3,044.8	3,044.8	1,013.8	49.9%	PPD Ops Fixed (T. Dee / J. Truax)
13 Housekeeping	187.1	187.1	187.1	187.1	0.0	0.0%	Pulls from Misc. Fixed Tab
14 Whse. Handling Fixed Allocation	0.0	86.5	86.5	86.5	86.5	#DIV/0!	Pulls from Misc. Fixed Tab
Other							
15 Amortization Svc Loaners	26.5	26.5	26.5	26.5	0.0	0.0%	Pulls from Misc. Fixed Tab
16 Utilities	99.8	99.5	99.5	99.5	-0.1	-0.1%	Pulls from Misc. Fixed Tab
17 Corp Copier Fixed Costs	0.0	0.0	0.0	0.0	0.0	0.0%	Pulls from Misc. Fixed Tab
18 R&D Internal Allocation	0.0	0.0	0.0	0.0	0.0	0.0%	Pulls from Misc. Fixed Tab
19 ABC Allocations	0.0	0.0	0.0	0.0	0.0	0.0%	Pulls from Misc. Fixed Tab
Subtotal PPNC/Other	2,872.9	3,766.9	3,766.9	3,766.9	1,094.0	40.9%	
Corporate Reallocations							
3 Subtotal Other Cost Expense Pools	n/a	n/a	n/a	n/a	#VALUE!		N/A
R&D Allocations							
Depreciation	32,562.8	31,308.5	31,308.5	31,308.5	-1,354.1	-4.1%	L:\GROUP\PLANNING\2001 PLAN\Floorspace\01floor.xls
Regu Floor Space	37,329.0	40,013.1	40,013.1	40,013.1	2,684.1	7.2%	L:\GROUP\PLANNING\libedexp\01fixedbim depr.wk4
Total Fixed (Group 40 for Functionals)	72,894.5	75,088.5	75,088.5	75,088.5	2,424.0	3.3%	
20 Total Cost Assignments Absorbed in Overh	42,244.5	40,081.1	40,081.1	40,081.1	-2,163.4	-5.1%	
Total Fixed/Overhead	114,909.0	115,169.6	115,169.6	115,169.6	260.6	0.2%	

L:\GROUP\PLANNING\2001 PLAN\Fixed Expenses\Burdens\1.dq\With Fixed
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**PPD ALLOC SUMMARY
FUNCTIONAL & C
HEAD EXPENSE
GROSS (\$000)**

Note: These charges are obtained from K. O'Rourke's group PPD Div. FPA; usually via PPD Kelly's

	1998	1999	%	2000	2001	2001	2001	%	Notes
	Total	Total	Increase	AGU	Plan	APU	AGU	Increase	
Other Cost Expense Pools - Kevin O'Rourke (PPD Div. FPA)									
Other taxes on purchases	63.6	63.6	0.0%	50.0	50.0	60.0	60.0	0.0%	
MFG Inventory Sales Tax	0.0	0.0	#DIV/0!	14.0	17.0	17.0	17.0	0.0%	
Insurance other PPAE	207.9	207.9	0.0%	182.0	115.0	115.0	115.0	-24.3%	
Insurance Auto/Truck	1164.0	1164.0	0.0%	1.6	1.6	1.6	1.6	0.0%	
Celebrity	1856.3	1856.3	0.0%	1,200.0	1,219.0	1,219.0	1,219.0	1.6%	
Security	688.4	688.4	0.0%	512.0	472.5	472.5	472.5	-7.7%	
Other Corp Admin	758.3	758.3	0.0%	0.0	0.0	0.0	0.0	0.0%	
Subtotal - Corp Admin	4,857.4	4,857.4	0.0%	1,928.8	1,875.3	1,875.3	1,875.3	-2.8%	Journal Entry: Direct from CHMS by 6A133 CHMS" to PPRD 7es-80
1 Satellite Copiers	904.0	904.0	0.0%	555.2	539.0	539.0	539.0	-2.9%	
1 Shuttle Bus	188.0	188.0	0.0%	111.0	134.0	134.0	134.0	20.7%	
1 Mailroom	625.0	625.0	0.0%	314.0	287.0	287.0	287.0	-8.4%	
1 CHMS-QSS Fixed Admin Svcs	548.0	548.0	0.0%	410.0	421.0	421.0	421.0	2.7%	
Library Info Services	Internal	Internal	0.0%	2,820.0	2,784.0	2,784.0	2,784.0	-1.3%	
Other Fixed from PPD Comm	131.0	131.0	0.0%	0.0	0.0	0.0	0.0	0.0%	
Subtotal Fixed from PPD Comm	2,282.0	2,282.0	0.0%	4,210.2	4,165.0	4,165.0	4,165.0	-1.3%	Journal Entry: Direct from CHMS by 6A133 CHMS" to PPRD 7es-80
1 Purchasing Fixed(CHMS)	1,870.0	1,870.0	0.0%	897.0	747.0	747.0	747.0	-20.7%	
1 Other TeleMail(CHMS) - MIS Telecomm	178.0	178.0	0.0%	116.0	130.0	130.0	130.0	12.1%	
1 PPD Mailroom (UPS)	110.0	110.0	0.0%	50.0	63.0	63.0	63.0	26.0%	
Subtotal Fixed from CHMS & PPD Ops	1,988.0	1,988.0	0.0%	873.0	940.0	940.0	940.0	7.7%	Journal Entry: Direct from CHMS by 6A133 CHMS" to PPRD 7es-80
Subtotal Other Cost Expense Pools	5,107.4	5,107.4	0.0%	7,013.0	6,870.3	6,870.3	6,870.3	-2.0%	
Corp Admin Expense Assignments - Kevin O'Rourke (PPD Div. FPA)									
1 LC Employment	130.0	130.0	0.0%	43.0	43.0	43.0	43.0	0.0%	
1 LC Skills Develop	21.0	21.0	0.0%	4.0	4.0	4.0	4.0	0.0%	
1 Corporate Training	138.0	138.0	0.0%	81.0	57.0	57.0	57.0	-30.4%	
1 LC Emp Skills Train College Relations	0.0	0.0	0.0%	0.0	0.0	0.0	0.0	0.0%	
Other Unit of Activity	321.0	321.0	0.0%	108.0	104.0	104.0	104.0	-3.7%	
Sub-Total Unit of Activity	610.0	610.0	0.0%	236.0	208.0	208.0	208.0	-10.6%	
1 Outside Audit Fees	0.0	0.0	#DIV/0!	0.0	0.0	0.0	0.0	0.0%	
1 Drug User Fees	1816.0	1816.0	0.0%	1,902.0	1,207.0	1,207.0	1,207.0	-33.0%	
1 Patents & Trademark	3919.0	3919.0	0.0%	5,985.0	6,050.0	6,050.0	6,050.0	1.1%	
Other Pass Thru Charges	2761.0	2761.0	0.0%	0.0	0.0	0.0	0.0	0.0%	
Sub-total Pass Thru Charge Basis	6386.0	6386.0	0.0%	7,387.0	7,267.0	7,267.0	7,267.0	-1.6%	
Corporate Licensing	726.0	726.0	0.0%	712.0	738.0	738.0	738.0	3.7%	
Account Payable	535.0	535.0	0.0%	352.0	343.0	343.0	343.0	-2.6%	
Legal Staff	2105.0	2105.0	0.0%	1,907.8	2,308.0	2,308.0	2,308.0	20.9%	
Regulatory Affairs	342.0	342.0	0.0%	368.0	481.0	481.0	481.0	30.1%	
Payroll	593.0	593.0	0.0%	228.0	214.0	214.0	214.0	-6.1%	
General Ledger System	0.0	0.0	#DIV/0!	0.0	0.0	0.0	0.0	0.0%	
Fixed Retainer Charge	1876.0	1876.0	0.0%	1,303.0	1,263.3	1,263.3	1,263.3	-3.0%	
Other Fixed Retainer	7840.0	7840.0	0.0%	0.0	0.0	0.0	0.0	0.0%	
Sub-total Corp Admin Fixed	14,117.0	14,117.0	0.0%	4,805.8	5,345.3	5,345.3	5,345.3	11.2%	
Subtotal Corp Admin	24,126.0	24,126.0	0.0%	12,388.8	12,706.3	12,706.3	12,706.3	2.6%	
Key Checks:									
Overhead - Burden	17,528.9	16,468.6	-6.3%	1,902.0	1,207.0	1,207.0	1,207.0	-36.1%	
Overhead - FDA Fees	0.0	0.0	0.0%	0.0	0.0	0.0	0.0	0.0%	
Library Info Services charged to clients	0.0	0.0	0.0%	0.0	0.0	0.0	0.0	0.0%	
Total Cost Pools & Assignments	19,378.8	19,378.8	0.0%	19,378.8	19,378.8	19,378.8	19,378.8	0.0%	

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Note: These charges are obtained from various memos (mainly from PPD Ops). These memos are detailed in the Fixed Expenses binder. All PARD expenses come from Steve Srostad directly (these should be in line with what PPD Ops has submitted (via J. Trax).

21601 021 774
LEADERSHIP TRAINING GOOD PLANNING and EXPENSES PLEASE CONTACT 7/8/84

HIGHLY
CONFIDENTIAL
ABBT 0037605

83

Fixed Allocations from Operations

(via J. Triax memo)

PD RD		2000		2001		PD Variances		RD Variances	
		Product Development	Research & Develop	Product Development	Research & Develop	\$	%	\$	%
11	WISDOM(On-Going)	189,000	138,700	183,000	139,650	-6,000	-3.2%	-50	0.0%
	EDMS (On Going)	255,000		255,000					
	EDMS Project Expense	85,000		0					
12	a) D-44K Stability (DOF)	75,000	440,400	75,000	524,800	0	0.0%	84,400	19.2%
12	24 CHEN Utilities	48,000	235,000	104,800	188,800	56,800	117.9%	-46,200	-19.7%
12	26 CHEN Maintenance	208,000	947,000	472,000	899,000	284,000	125.9%	-48,000	-5.1%
12	22 PA ABC Allocations	682,000	68,675	778,000	68,600	96,000	14.1%	-75	-0.1%
12	27 QA ABC Allocations	978,000	1,438,000	1,320,000	1,942,000	342,000	35.0%	504,000	35.0%
23	CAPD Warehouse/Waste		83,648		81,773	0		-1,875	-2.2%
28	CAPD Project Exp. Transfer		105,000		105,000	0		0	0.0%
26	D-55A Engineering Support		268,000		375,000	0		107,000	39.9%
21	Corp. Eng. Proj. Expense		1,426,000		1,993,000	0		567,000	39.8%
12	D-55T Calibration Serv/c	40,000		40,000		0	0.0%	0	
29	CHEN Envir Health & Saf	0	568,000	0	597,000	0		39,000	7.0%
	Total	2,560,000	6,709,423	3,227,600	8,814,623	667,600	26.1%	1,205,200	21.1%

a) Not Included in overhead; charged directly to projects.

L:\GROUP\PLANNING\2001 PLAN\Fixed Expenses\Burdens\Main Fixed
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Key Unfunded List

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PPD - Research and Development
2001 PLANKey Unfunded Projects
(SMM's)

(As of 11/5/2001)

Drug/Compound	Project Description	2001 PLAN
NEUROLOGY		
Depakote	New Formulations (Epilepsy & Acute Migraine)	1.9
Depakote	Bipolar in Pediatric Market	1.4
ABT-594	Post Milestone Funding (3rd and 4th Quarter)	9.8
ABT-594	Phase IB Osteoarthritis Study (assumes 1/1/01 start date)	5.8
ABT-594	Additional Acute Pain Study (Phase IB Molar Extraction Study)	3.0
COX-II	Ongoing Pre-Clinical Studies	3.0
ABT-089	Single/Multiple Rising Dose Phase I Study	7.0
ABS-103	Pre-Clinical Studies	3.3
ABS-103	Single Rising Dose Phase I Study	2.4
NPS-1778	Pre-Clinical Studies	3.7
NPS-1778	Single and Rising Multiple Phase I and Formulation Bio Studies	2.4
Subtotal NEUROLOGY		43.7
ANTI-INFECTION		
Clarithromycin	Asthma/Immunomodulatory Studies	2.4
ABT-773	ABT-773 IV Development Cost	8.0
Quinestron (ABT-492)	Phase II Acceleration/Expansion of Clinical Studies	6.7
Quinestron (ABT-492)	IV Formulation	4.0
Quinestron (ABT-492)	Japan Phase I Study	1.0
Omnicef	Pharyngitis/Tonsillitis Study; Pediatrics, Suspension, 50 BID vs. Zithromax	4.0
Omnicef	ABEC8 - Two Arm Study 50 QD vs. Comparator	2.4
Subtotal ANTI-INFECTION		31.5
UROLOGY		
Fenofibrate	Diabetes	4.0
Bimoclomol	Phase II Studies	10.0
KCO	Pre-Clinical/Phase I Studies	6.0
Subtotal UROLOGY		20.0
HIV/IMMUNOLOGY		
Kaletra	Phase IB Program (unfunded portion)	6.6
Kaletra	Kaletra QD	4.2
Kaletra	Post Approval Commitments	4.2
Kaletra	Kaletra Salvage	2.8
Kaletra	Kaletra Firstline	2.8
Kaletra	Expanded Access Program	1.8
Kaletra	Phase IV RTI	1.3
Kaletra	BIHSC Cohort	1.0
Kaletra	Metabolite Program	0.8
Kaletra	Miscellaneous Phase IV Studies	0.7
Subtotal HIV/IMMUNOLOGY		24.8
ONCOLOGY		
ABT-627	Early Stage Pca Cancer	11.0
K-5	Pre-Clinical/Phase I Studies	8.8
Subtotal ONCOLOGY		19.8
DISCOVERY		
DDCs	Development of DDC's	7.7
UNLICENSED COMPOUNDS		
Various	Funds to Acquire New Compounds	7.7
PRODUCTIVITY		
30% Reduction in Capital	Productivity Projects	6.0
	Rosetta Gene Expression	
	Genomical/HTS Expansion Program	
	AEGR MedDRA	

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Deposition Exhibit 30

P's Exhibit BL

Timeline of events occurring with Study M00-235 in the Netherlands
--

14 february 2001	Site initiation Schellens, Amsterdam
15 february 2001	Site initiation Zonnenberg, Utrecht
7 march 2001	Nisan (DVP, Oncology, Abbott US) and Nabulsi (Oncology head, Abbott US) attended Abbott senior management review: "concern regarding the continuation of ABT-518 development"
11 march 2001	Nabulsi (Oncology head, Abbott US) calls Looman (ass. Med Dir Oncology, Abbott NL) to inform about immediate stop ABT-518 project (and thus study M00-235). Janus (Med. Dir Oncology, Abbott US) and D'Amico (PM, Oncology, Abbott US)
12 march 2001	Looman calls Schellens and Zonnenberg and requests to NOT enroll any patients due to decision Abbott to stop study Zonnenberg has enrolled patient 1001; Schellens did not enrol a patient awaiting BoD approval D'Amico sends Beerepoort (sub-I, Utrecht) memo to allow continuation with pat 1001 and await further news (expected on 13 Mar 01); no new patients to be enrolled. Schellens also informed by memo (D'Amico). Abbott informs Schellens and Zonnenberg that study hold has been lifted.
13 march 2001	1001 stops study due to DP (and dies on 30 apr 01 due to cerebral mets)
23 march 2001	Schellens enrolls Pat 1002
26 march 2001	Zonnenberg enrolls pats 1003 & 1004
23 april 2001	Pat 1002: SAE (dyspnea/pleural effusion), probably not related
25 april 2001	ASCO: discussion by Abbott and sites: no safety issues: go to level 2 (50 mg)
12-16 may 2001	Memo Janus confirming escalation to level 2 (50 mg) per 21 May 2001
18 may 2001	Pat 1002 withdraws consent (due to SAE)
21 may 2001	Start patient first patient on 50 mg at NKI - 1101 JOE
22 may 2001	Start AE of 1004 (day 29 of study) - Rise of Creatinin: possibly related
25 may 2001	Hospitalization pat 1004: AE → SAE
25 may 2001	Initial SAE report pat 1004 to Abbott Safety Desk: relationship: possible related due to rising creatinin: DLT
26 may 2001	Stop medication pat 1004 to allow decrease of toxicity to within one level of baseline
30 may 2001	Follow-up SAE report; relationship: possible caused by kidney failure
30 may 2001	Zonnenberg sends letter to EC regarding pat 1002 reporting SAE: relapse pleural effusion needs to be changed into dyspnea
1 june 2001	MMPI project (ABT-518) deemed a NoGo by senior management
5 june 2001	Teleconference Abbott - Zonnenberg: relationship SAE 1004 is still possibly related, but needs to be probably not related, if enrollment of new patients at level 2 (50 mg) can continue. Schellens; 2 nd patient 1102 NKI is waiting to be included. Decision Abbott to suspend enrollment to clarify renal toxicity, based on suggestion by Zonnenberg. Patient 1004 stops study due to SAE Verbal announcement of Abbott (Nabulsi) to stop study to Schellens and Zonnenberg
12 june 2001	Teleconference with Voest to officially inform him of study termination
14 june 2001	1003 stops study due to DP
19 june 2001	Teleconference with Schellens to officially inform him of study termination
21 june 2001	After this call, an official study termination letter was sent to Schellens and Zonnenberg
22 june 2001	Receipt of registration form of proposed 2 nd patient at 50 mg by Schellens
22 june 2001	Memo Janus: relationship SAE 1004 will be changed to: probably not; Schellens to announce 2 nd patient at 50 mg; official paperwork from Zonnenberg to confirm changed relationship pending

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FOR I.D. 426-07-1 JAC

25 June 2001	2nd patient at 50 mg included 1102 by Schellens, however no documentation of changed relationship received from Zonnenberg. Patient should have received 25 mg due to possible DLT
26 June 2001	Visit Nabulsi to both sites to explain termination of study
6 July 2001	Conference call with Schellens asking him to not enroll new patients at 50 mg; Statement from Schellens that no more patients as of 6 Jul 01 except for pat 1101 have been enrolled at 50 mg
7 July 2001	Memo Janus to indicate that relationship has not changed, so any new patient should receive 25mg.
11 July 2001	Memo of datanurse of Zonnenberg signaling unawareness of changed relationship from probably not back to possible
12 July 2001	Renewed request to Schellens to confirm that no new patients after pat 1101 have been enrolled; Additional information received by Janus about inclusion of second patient 1102 on 25 June 01
25 July 2001	Memo from Schellens to inform Abbott that patient 1102 will continue on 50 mg, no drug related toxicities.
27 July 2001	Memo Knight (PM, Abbott Oncology US): Nabulsi agrees with proposed strategy by Schellens. Protocol deviation noted and will be reported correctly.
31 July 2001	Zonnenberg letter to Janus: Relationship SAE pat 1004 remains possibly related; recommendation Zonnenberg to add 3 more patients @ 25 mg.
10 Dec 2001	Zonnenberg sends corrective letter to EC to change description of SAE pat 1002 from "relapse pleural effusion" to "dyspnea". Content and outcome SAE have not changed.
30 Nov 01	Close out visit Schellens
11 Dec 2001	Close out visit Zonnenberg

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Deposition Exhibit 33

P's Exhibit GI



Tamara L
Garavalia /LAKE/PPRD/ABB
OTT

10/09/2001 10:25 AM

To: Linda M Fisher/LAKE/PPRD/ABBOTT@ABBOTT
cc
bcc
Subject: ABT-594 Not Funded

So - now that you have a lot of free time - you can go out for lunch more often! (Ha Ha - bet you thought I was going to push another project your way!)

tg

----- Forwarded by Tamara L Garavalia/LAKE/PPRD/ABBOTT on 10/09/01 10:25 AM -----



Gary D Jones
10/09/01 10:04 AM

To: D492
cc: Patrick M Klemens/LAKE/PPRD/ABBOTT@ABBOTT
Subject: ABT-594 Not Funded

FYI

----- Forwarded by Gary D Jones/LAKE/PPRD/ABBOTT on 10/09/01 10:03 AM -----

Howard S Chesdin
10/09/01 09:44 AM

To: Claudia M Davila/LAKE/PPRD/ABBOTT@ABBOTT, David G Stroz/LAKE/PPRD/ABBOTT, Diana L Green/LAKE/PPRD/ABBOTT@ABBOTT, Enskine R Hillyer/LAKE/PPRD/ABBOTT@ABBOTT, Eugenia Gotsis/LAKE/PPRD/ABBOTT@ABBOTT, Jenny M Chan/LAKE/PPRD/ABBOTT@ABBOTT, Ji Zhou/LAKE/PPRD/ABBOTT@ABBOTT, Jim J Chulio/LAKE/CAPD/ABBOTT@ABBOTT, John E Hengeveld/LAKE/CAPD/ABBOTT@ABBOTT, Linda M Fisher/LAKE/PPRD/ABBOTT@ABBOTT, Lloyd S Dias/LAKE/PPRD/ABBOTT@ABBOTT, Megan R Hughes/LAKE/PPRD/ABBOTT@ABBOTT, Michael L Branton/LAKE/PPD/ABBOTT@ABBOTT, Rhonda J Peck/LAKE/PPRD/ABBOTT@ABBOTT, Sanjeev Sharma/LAKE/PPRD/ABBOTT@ABBOTT, Shyamala C Jayaraman/LAKE/PPRD/ABBOTT@ABBOTT, Smriti S Desai/LAKE/PPRD/ABBOTT@ABBOTT, Stephen J Vigmond/LAKE/PPRD/ABBOTT@ABBOTT, Thomas J Myers/LAKE/PPRD/ABBOTT@ABBOTT, Victoria H Estrada/LAKE/PPRD/ABBOTT@ABBOTT, William T Monte/LAKE/CAPD/ABBOTT@ABBOTT
cc: Ashok Katdare, Elraim Shek/LAKE/PPRD/ABBOTT@ABBOTT, Dana K Morgan/LAKE/PPRD/ABBOTT@ABBOTT, Richard A Pyter/LAKE/PPRD/ABBOTT@ABBOTT, Liam Feely, Gary D Jones/LAKE/PPRD/ABBOTT@ABBOTT, Steve Szostak/LAKE/PPRD/ABBOTT@ABBOTT
Subject: ABT-594 Not Funded

An outcome of yesterday's Pharmaceutical Executive Committee meeting was to kill ABT-594. There will be attempts to outlicense the compound since the risk/value assessment came up with a positive net present value, but it will not be developed by Abbott.

Please discontinue all project activities related to the clinical supply. We will work out the close-down activities in the next couple of weeks.

Howard

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ABB0148334

Leiden EXHIBIT *33*
FOR I.D. *4-26-07* *1-jan*

Deposition Exhibit 35

P's Exhibit GL

1 ABBOTT

Daphne L. Pals
Senior Counsel

Abbott Laboratories
100 Abbott Park Road
Abbott Park, Illinois 60064-6049
Telephone: (847) 935-5747
Telecopy: (847) 938-1206

November 16, 2001

Mr. Steve Blewitt
John Hancock Life Insurance Company
200 Clarendon Street, T-57
Boston, MA 02117
Attention: Bond & Corporate Finance Group
Fax: 617-572-1628

Re: Research Funding Agreement dated as of March 13, 2001
Termination of ABT-594

Dear Steve,

This is to advise you that Abbott has decided to terminate further development of ABT-594 (a drug for the treatment of neuropathic pain).

Section 4.3(c) of the Agreement is not applicable as the cessation of the development of ABT-594 was not the result of Abbott's acquisition of a Replacement Compound. Abbott will attempt to maximize the commercial value, if any, of ABT-594 as required under Section 4.3(d).

I hope you are doing well.

Sincerely,

Daphne Pals
Senior Counsel

cc: John Hancock Life Insurance Company
200 Clarendon Street, T-50
Boston, MA 02117
Attention: Investment Law Division
Fax: 617-572-9268

Handwritten notes and calculations:

822
(12) 725 from 50+18 W8
(24) 101 1585 - 5 Actual
(52) 120
\$ 733.00 17 4/5/02
~~101 1585 - 5 Actual~~

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242 308 found
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Set forth
Spent 101-104
Mark 8/14
101 ABT + 0240
723

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ABBT 0033833

Leiden EXHIBIT 35
FOR ID. 4-26-07- gk

Deposition Exhibit 37

P's Exhibit I

February 2001

ABT-518

Phase	Phase Name	Start Date	End Date	Phase ID	Phase Description
Phase 1	Phase 1	1/1/00	12/31/00	100	Phase 1
Phase 2	Phase 2	1/1/01	12/31/01	200	Phase 2
Phase 3	Phase 3	1/1/02	12/31/02	300	Phase 3
Phase 4	Phase 4	1/1/03	12/31/03	400	Phase 4
Phase 5	Phase 5	1/1/04	12/31/04	500	Phase 5
Phase 6	Phase 6	1/1/05	12/31/05	600	Phase 6
Phase 7	Phase 7	1/1/06	12/31/06	700	Phase 7
Phase 8	Phase 8	1/1/07	12/31/07	800	Phase 8
Phase 9	Phase 9	1/1/08	12/31/08	900	Phase 9
Phase 10	Phase 10	1/1/09	12/31/09	1000	Phase 10
Phase 11	Phase 11	1/1/10	12/31/10	1100	Phase 11
Phase 12	Phase 12	1/1/11	12/31/11	1200	Phase 12
Phase 13	Phase 13	1/1/12	12/31/12	1300	Phase 13
Phase 14	Phase 14	1/1/13	12/31/13	1400	Phase 14
Phase 15	Phase 15	1/1/14	12/31/14	1500	Phase 15
Phase 16	Phase 16	1/1/15	12/31/15	1600	Phase 16
Phase 17	Phase 17	1/1/16	12/31/16	1700	Phase 17
Phase 18	Phase 18	1/1/17	12/31/17	1800	Phase 18
Phase 19	Phase 19	1/1/18	12/31/18	1900	Phase 19
Phase 20	Phase 20	1/1/19	12/31/19	2000	Phase 20
Phase 21	Phase 21	1/1/20	12/31/20	2100	Phase 21
Phase 22	Phase 22	1/1/21	12/31/21	2200	Phase 22
Phase 23	Phase 23	1/1/22	12/31/22	2300	Phase 23
Phase 24	Phase 24	1/1/23	12/31/23	2400	Phase 24
Phase 25	Phase 25	1/1/24	12/31/24	2500	Phase 25
Phase 26	Phase 26	1/1/25	12/31/25	2600	Phase 26
Phase 27	Phase 27	1/1/26	12/31/26	2700	Phase 27
Phase 28	Phase 28	1/1/27	12/31/27	2800	Phase 28
Phase 29	Phase 29	1/1/28	12/31/28	2900	Phase 29
Phase 30	Phase 30	1/1/29	12/31/29	3000	Phase 30
Phase 31	Phase 31	1/1/30	12/31/30	3100	Phase 31
Phase 32	Phase 32	1/1/31	12/31/31	3200	Phase 32
Phase 33	Phase 33	1/1/32	12/31/32	3300	Phase 33
Phase 34	Phase 34	1/1/33	12/31/33	3400	Phase 34
Phase 35	Phase 35	1/1/34	12/31/34	3500	Phase 35
Phase 36	Phase 36	1/1/35	12/31/35	3600	Phase 36
Phase 37	Phase 37	1/1/36	12/31/36	3700	Phase 37
Phase 38	Phase 38	1/1/37	12/31/37	3800	Phase 38
Phase 39	Phase 39	1/1/38	12/31/38	3900	Phase 39
Phase 40	Phase 40	1/1/39	12/31/39	4000	Phase 40
Phase 41	Phase 41	1/1/40	12/31/40	4100	Phase 41
Phase 42	Phase 42	1/1/41	12/31/41	4200	Phase 42
Phase 43	Phase 43	1/1/42	12/31/42	4300	Phase 43
Phase 44	Phase 44	1/1/43	12/31/43	4400	Phase 44
Phase 45	Phase 45	1/1/44	12/31/44	4500	Phase 45
Phase 46	Phase 46	1/1/45	12/31/45	4600	Phase 46
Phase 47	Phase 47	1/1/46	12/31/46	4700	Phase 47
Phase 48	Phase 48	1/1/47	12/31/47	4800	Phase 48
Phase 49	Phase 49	1/1/48	12/31/48	4900	Phase 49
Phase 50	Phase 50	1/1/49	12/31/49	5000	Phase 50
Phase 51	Phase 51	1/1/50	12/31/50	5100	Phase 51
Phase 52	Phase 52	1/1/51	12/31/51	5200	Phase 52
Phase 53	Phase 53	1/1/52	12/31/52	5300	Phase 53
Phase 54	Phase 54	1/1/53	12/31/53	5400	Phase 54
Phase 55	Phase 55	1/1/54	12/31/54	5500	Phase 55
Phase 56	Phase 56	1/1/55	12/31/55	5600	Phase 56
Phase 57	Phase 57	1/1/56	12/31/56	5700	Phase 57
Phase 58	Phase 58	1/1/57	12/31/57	5800	Phase 58
Phase 59	Phase 59	1/1/58	12/31/58	5900	Phase 59
Phase 60	Phase 60	1/1/59	12/31/59	6000	Phase 60
Phase 61	Phase 61	1/1/60	12/31/60	6100	Phase 61
Phase 62	Phase 62	1/1/61	12/31/61	6200	Phase 62
Phase 63	Phase 63	1/1/62	12/31/62	6300	Phase 63
Phase 64	Phase 64	1/1/63	12/31/63	6400	Phase 64
Phase 65	Phase 65	1/1/64	12/31/64	6500	Phase 65
Phase 66	Phase 66	1/1/65	12/31/65	6600	Phase 66
Phase 67	Phase 67	1/1/66	12/31/66	6700	Phase 67
Phase 68	Phase 68	1/1/67	12/31/67	6800	Phase 68
Phase 69	Phase 69	1/1/68	12/31/68	6900	Phase 69
Phase 70	Phase 70	1/1/69	12/31/69	7000	Phase 70
Phase 71	Phase 71	1/1/70	12/31/70	7100	Phase 71
Phase 72	Phase 72	1/1/71	12/31/71	7200	Phase 72
Phase 73	Phase 73	1/1/72	12/31/72	7300	Phase 73
Phase 74	Phase 74	1/1/73	12/31/73	7400	Phase 74
Phase 75	Phase 75	1/1/74	12/31/74	7500	Phase 75
Phase 76	Phase 76	1/1/75	12/31/75	7600	Phase 76
Phase 77	Phase 77	1/1/76	12/31/76	7700	Phase 77
Phase 78	Phase 78	1/1/77	12/31/77	7800	Phase 78
Phase 79	Phase 79	1/1/78	12/31/78	7900	Phase 79
Phase 80	Phase 80	1/1/79	12/31/79	8000	Phase 80
Phase 81	Phase 81	1/1/80	12/31/80	8100	Phase 81
Phase 82	Phase 82	1/1/81	12/31/81	8200	Phase 82
Phase 83	Phase 83	1/1/82	12/31/82	8300	Phase 83
Phase 84	Phase 84	1/1/83	12/31/83	8400	Phase 84
Phase 85	Phase 85	1/1/84	12/31/84	8500	Phase 85
Phase 86	Phase 86	1/1/85	12/31/85	8600	Phase 86
Phase 87	Phase 87	1/1/86	12/31/86	8700	Phase 87
Phase 88	Phase 88	1/1/87	12/31/87	8800	Phase 88
Phase 89	Phase 89	1/1/88	12/31/88	8900	Phase 89
Phase 90	Phase 90	1/1/89	12/31/89	9000	Phase 90
Phase 91	Phase 91	1/1/90	12/31/90	9100	Phase 91
Phase 92	Phase 92	1/1/91	12/31/91	9200	Phase 92
Phase 93	Phase 93	1/1/92	12/31/92	9300	Phase 93
Phase 94	Phase 94	1/1/93	12/31/93	9400	Phase 94
Phase 95	Phase 95	1/1/94	12/31/94	9500	Phase 95
Phase 96	Phase 96	1/1/95	12/31/95	9600	Phase 96
Phase 97	Phase 97	1/1/96	12/31/96	9700	Phase 97
Phase 98	Phase 98	1/1/97	12/31/97	9800	Phase 98
Phase 99	Phase 99	1/1/98	12/31/98	9900	Phase 99
Phase 100	Phase 100	1/1/99	12/31/99	10000	Phase 100

1 of 1

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ABBT 0000343

Lead 37

FOR ID 4-26-07 1 Jax

February 2001

ABT-518

- Study initiation visits were conducted on 2/14 and 2/15.

Key Program Milestones	Resolution Date
• First patient enrolled	3/12
• Preliminary results from 6-week rat hepatotoxicity study	3/31
• Pre-IND meeting with FDA	6/1
• Preliminary results from 3-month rat chronic toxicity study	6/30

Key Program Milestones	Resolution Date
Identification of FDA requirements for cytostatic agents in oncology drug development.	6/1/01
Key tox finding was hepatotoxicity in one-month rat study. <i>In-vitro</i> and <i>in-vivo</i> data indicate a potential for mechanism based drug interactions.	7/1/01

Phase I IND study to Transition program to solicit FDA input.

Phase I IND study to Transition program to solicit FDA input.

Phase I IND study to Transition program to solicit FDA input.

Phase I IND study to Transition program to solicit FDA input.

The Phase I first-in-man protocol has been designed to address these issues. A 6-week tox and metabolism studies have been completed. Results are under review. A 3-month rat toxicity study is ongoing.

The Phase I first-in-man protocol has been designed to address these issues. A 6-week tox and metabolism studies have been completed. Results are under review. A 3-month rat toxicity study is ongoing.

The Phase I first-in-man protocol has been designed to address these issues. A 6-week tox and metabolism studies have been completed. Results are under review. A 3-month rat toxicity study is ongoing.

The Phase I first-in-man protocol has been designed to address these issues. A 6-week tox and metabolism studies have been completed. Results are under review. A 3-month rat toxicity study is ongoing.

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February 2001

ABT-518

Phase of Development	Cost <input type="checkbox"/> Time <input checked="" type="checkbox"/> Profile <input type="checkbox"/> Regulatory <input type="checkbox"/>	Competitive Environment	Resolution Date Planned / Actual
As several competitors are in Phase II/III, ABT-518 product profile will need to demonstrate advantage over the other compounds (i.e., safety/efficacy)	<input type="checkbox"/> Cost <input type="checkbox"/> Time <input checked="" type="checkbox"/> Profile <input type="checkbox"/> Regulatory <input type="checkbox"/>	Ongoing analysis and comparison of competition throughout transition. ABT-518 has the potential to be the best in class compound. Pfizer (Agouron) announced B4400 that they were stopping Phase III trials of pirarimastat in advanced prostate and NSCLC because "primary efficacy objectives were not met". They are continuing trials in less advanced tumors, e.g., glioma and NSCLC, and will start trials in two additional tumor types. Efficacy was shown with marimastat in less advanced gastric cancer, but British Biotech announced on 9/27/00 that marimastat in combination with carboplatin was no better than carboplatin alone in advanced ovarian cancer. Marimastat development was discontinued on 2/15/01. Both the Pfizer compound and British Biotech's compound are hindered by dose-limiting joint toxicity.	
	<input type="checkbox"/> Cost <input type="checkbox"/> Time <input type="checkbox"/> Profile <input type="checkbox"/> Regulatory <input type="checkbox"/>		

3 of 3

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February 2001

ABT-518

Key Activities

Commercial		
Activity	LSE	Actual
Market research to assess commercial potential of cancer types, both US and Ex-US	4/2001	
Assessment of patient compliance (for revision of forecast)	3/2001	
Assessment of off-label vs. on-label use (for revision of forecast)	3/2001	
Assessment of cancer market growth (for revision of forecast)	4/2001	
Assist with advisory planning	4/2001	
Development of brand and generic names	Late 2001	

Formulation		
Activity	Plan	Actual
Phase I Formulation	10/2000	
Phase II Formulation		
Formulation for Bio Study		
Phase III Clinical Supplies Manufactured		
NDA Lots (3) Completed		
Completion of 1 Year Stability for NDA		
Formulation Peer Review		

Drug Substance

Drug Substance		
Activity	KG	Actual Projected Costing
Chem Sclen (GLP)	3,01.7	\$133,300
Chem Sclen (GMP)	2,03.8	\$133,300
Chem Sclen	15.0	
SPD		
SPD		
Dime Lot		
NDA Lot #1		
NDA Lot #2		
NDA Lot #3		
Validation Lot		

Toxicology		
Toxicology Activity	Planned Start	Actual Start Date
Gene Toxicology	5/2000	
Acute Studies	5/2000	
2-Week Monkey (non-GLP)	12/1999	12/14/99
1-Month Rat (non-GLP screening)	12/1999	12/14/99
1-Month Rat (GLP)	6/2000	6/27/00
1-Month Monkey (GLP)	6/2000	6/29/00
3-Month Rat	1/2001	12/01
3-Month Mouse MTD		
SEG I and SEG II		
SEG III Rat (post retail development)		
6-Month Rat		
1-Year Monkey		
Carcinogenicity (2 yr) Rat		
Carcinogenicity (2 yr) Mouse		

4 of 4

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February 2001

ABT-518

All Clinical Studies:

Protocol Number	Phase	Study Name	Start 1 st Pt. Dosed	End (Last CRF In)	Patients		Protocol Number	Phase	Study Name	Start 1 st Pt. Dosed	End (Last CRF In)	Patients	
					Target	Current						Target	Current
MOO-235	I	IND Study in cancer patients	2/28		40								
TBD	I	IND Study			20								

5 of 5

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February 2001

ABT-518

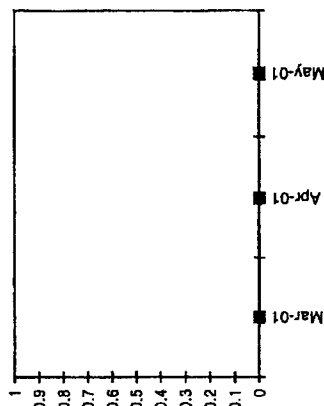
Ongoing Clinical Studies (List first time in man, Phase II Dose-Ranging and Pivotal Trials)

Protocol: M00-235 - Phase I MD in cancer patients
 Objective: Determine MTD and safety profile in cancer patients
 ABT-518 Doses: 25, 50, 100, 200, 400, 800, 1200, 1600, 2000 mg/day
 Comparator Doses: N/A
 Target Enrollment: 40
 Status: Study initiated, clinical supplies delivered
 Major Findings:

M00-235 - TITLE

Actual
 Target

Enrollment



(Author:
 Double click on chart to
 edit)

D:\77Z\MP\SRs\ABT-518.doc

6 of 6

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Deposition Exhibit 40

P's Exhibit MI

MMPI MONTHLY MEETING AGENDA
4/12/2001, 10:30-12:00, AP6A-1A
Objectives: To Review MMPI Project Status

Anne
 Hagey - Rotokas
 MD

NOTES

- I. Toxicology - L. Loberg**
- Sticker*
Will
 • Results from 6 week rat study
 • 3 month rat - (RX phase ends this week)
- II. PK - B. Carr/ M. Rieser**
- Will post*
3 month complex
data
 • No update
- III. PARD - J. Cannon/ T. Garavalia/ S. Wittenberger**
- John*
Stuart
 • Capsules analysis, Feton run- 101% against claim
 • Process research is making additional drug
- IV. Discovery - S. Davidson**
- No Update
- V. Metabolism - D. Hickman**
- Dec*
III
 • Rat ADME study update
 ↳ Single Dose
- VI. Clinical- D. D'Amico**
- PK method validation update- Netherlands
 -Day 1 PK samples from 2 patients collected
 • 2 patients enrolled, 1 active
 • 2 patients scheduled to enroll 4/23
 • IND document collection continues

Next Team Venture Meeting

When: Thursday, May 10, 2001
 Where: AP6A-1A
 Time: 10:30 - 12:00

Per Pargy
 Kill scenario: Leiden wants to make
 Graphs Go Decision Based
 on Competitive Data @
 ASCO; committed
 IND Study: NIH: New/Dec. ish earliest start

III. Still investigation low yield
John
 • bulk density of several drug
 mean it feels more you shake
 - bulk density? (more compact) over time
 and @ higher standard deviation of
 empty capsules: more narrow
 range for all capsules
Stuart
 Proposing to analyze more material
 3 steps, ~~run~~ in June/pt
 each run with take 2 wks
 expect 15 kg
 + Needs to find out pilot plant
 availability
 Steve - Put on Hold Now; Will get back to you
 Diaper - Late @ Remain earth (will use
 NIH, Kharic studies need to be considered)

I - Peak of elimination - Res almost entirely
 - profile of metabolites very different in
 bile duct cannulated animals vs Res
 - 1/2 life of 2 days for metabolite (picks up
 where parent left off) - we got
 blood not in rodent PK

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ABBT0045243

Leiden
 EXHIBIT 40
 FOR I.D. 4-26-07 1 JHK

sulphonic acid → see in rat tissue extracts now - wasn't seen before
 - presume it's sulfuric acid (metabolite that has long 1/2 life)
 - why didn't we see sulfuric acid?
 We didn't see it in monkeys, etc. → only seeing it in rats so far
 so started w/ new HPLC system to re-analyse rat & monkey tissue & plasma samples

In Plasma: 518 & sulfuric acid
 In feces - see others

* Should I Δ the protocol to have a w/o for sintonin & anti-coagulants

2nd Meeting

Strategy: Perry Plan to Kill if Leiden Says ~~No Go~~

Jeff wants to kill this; ARCO results neutral - negative; No ⊕

Shelf (Opt 1) Kill - Hard Kill
 (Opt 2) Stop everything - try to out-license (sell); keep doing stability, etc; it already contains
 (Opt 3) Put it on pause until ???
 Offer pre-emptive plan for development → show how it shows/don't show benefit
 Move forward (Perry choice)

Put a plan in place - knowing where they are & what will do

Auguron - Add on to therapy
 Proximal disease vs advanced disease
 ? joint effects?
 Capture non-oncologic indications
 ⊗ how do we study proximal vs advanced

SAFETY
 (joint) - should answer in Phase II
 ↓ prohibits chronic drug administration
 If we cut all new w/o numbers finishing - partner will pick up

Perry wants to give Jeff a white sheet now

Activity - Can answer in another Phase I study
 PD → Intergate tumor tissues in melanoma & head & neck
 (II study) Xygonophy - approach

Locally invasive disease
 (ACI, BE, PIR, DCIS) - early bladder cancer...
 entity measured
 May even work by itself
 Can we cure/tx them?

Page 2

Other possibilities

Non Cancer :

MS
Fibrosis — hepatic fibrosis
proliferate ~~the~~ ^{APF} failure
retinopathy

IPF =
easy to measure
very attractive field
↓
"immunology franchise"

Recent Plan to John/Jeff now (or May 4, 5th)

Nobody has ever gotten approval
for locally invasive disease.
History weak

Marinistat works in MS models. Does ours? Not known.
Can we do some pre-clinical work?

Steve: will give list of non-cancer to Loefer & Perry to
build stories for both

Finish Safety Study = \$X Spend
If we move onto other — Gain \$X
Show Benefit

"Enthusiasm is inversely proportional to knowledge" — Perry

Deposition Exhibit 45

P's Exhibit IN

PART 1

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ABT-773 Update February 12, 2001

ABBT205047

hardem 45
EXHIBIT
FOR ID. 4.26.07.1.95x

Agenda

- Introduction
- The molecule
- Phase III tablet program Issues
 - QT
 - Live Function
 - Dosing
 - Microgram
 - Pediatric program
 - Japan program

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ABB1205046

Global Antibiotic Market Sales Current vs Future Projection

1999 Global Sales \$20.6B

2005 Global Sales \$25.3B

The antibiotic market is a large market and is
expected to expand on a global sales basis

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ABBT205049

Global Market Drivers Negative vs Positive Drivers

- **Antibiotic Resistance**
Increasing sensitivity toward "appropriate use" may have negative impact on usage ↓
Requires new agents to keep ahead of resistant pathogens; substitution of older generic agents with newer branded agents ↑
- **Patent Expirations**
May increase price sensitivity and bargaining power of MGAs ↓
Use of generic agents tend to decrease over time; obsolescence/resistance may further that trend ↓
- **Market expansion** ↑
- **Unmet Need** ↓
 - Overall unmet need relatively low
 - Cost, reimbursement, and ability to pay on added importance
 - Increased use of limited dollar metrics i.e. MICs, resistance surveillance, AUC/MIC, MPC, kill kinetics
- **Competition**
 - Increased competition from 1st generics; Avella, Aquin, Facive, Spectracef, Keitek, Zyvox
 - Competition from generic manufacturers; key competitors

Negative driver ↓
Positive driver ↑

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Key Success Factors U.S. vs ex-US

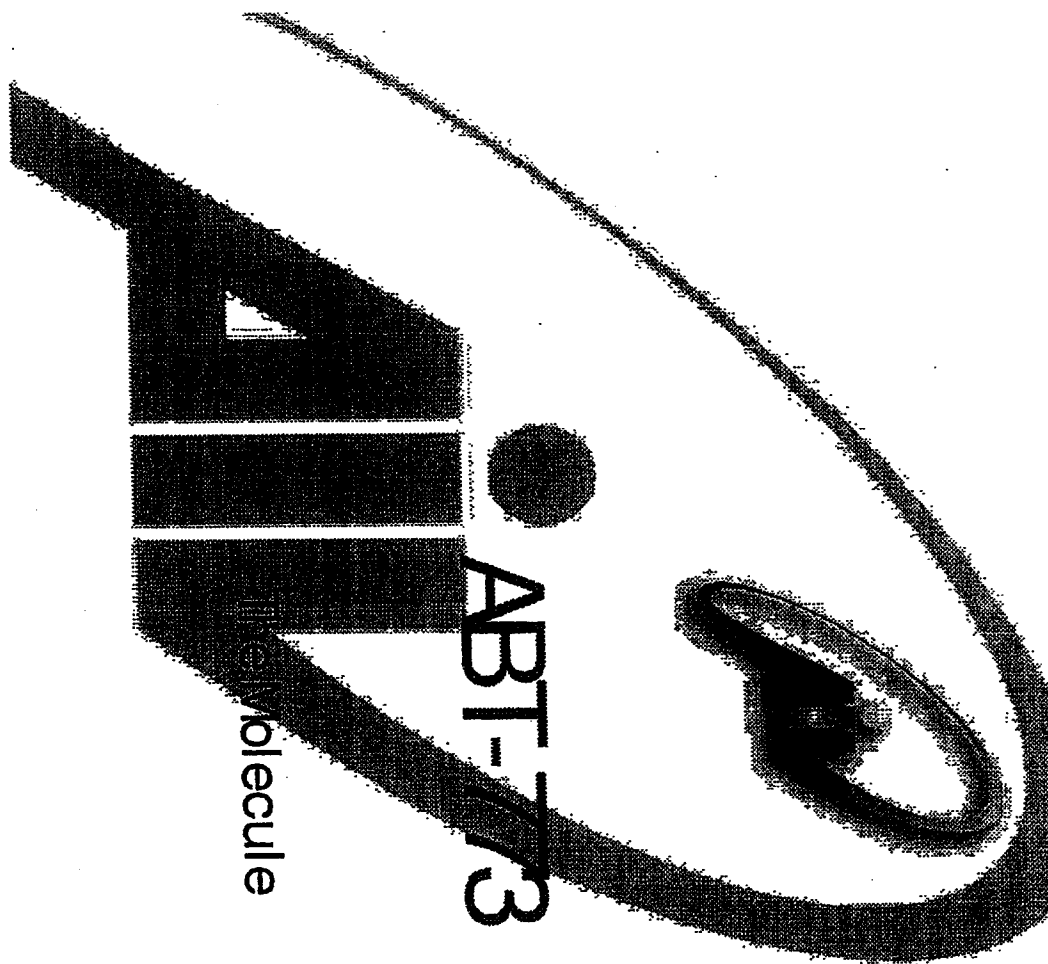
U.S. Assessment		Ex-US Assessment	
1. U.S. has a strong legal system with a high degree of transparency and accountability.	2. U.S. has a strong economy with a high degree of innovation and productivity.	3. U.S. has a strong military with a high degree of technological sophistication and combat readiness.	4. U.S. has a strong cultural and social fabric with a high degree of cohesion and stability.
5. U.S. has a strong diplomatic presence with a high degree of influence and respectability.	6. U.S. has a strong scientific and technological base with a high degree of research and development.	7. U.S. has a strong financial system with a high degree of liquidity and stability.	8. U.S. has a strong environmental record with a high degree of protection and conservation.
9. U.S. has a strong educational system with a high degree of quality and access.	10. U.S. has a strong healthcare system with a high degree of efficiency and effectiveness.	11. U.S. has a strong energy sector with a high degree of production and distribution.	12. U.S. has a strong transportation system with a high degree of connectivity and efficiency.
13. U.S. has a strong information sector with a high degree of innovation and productivity.	14. U.S. has a strong media sector with a high degree of freedom and expression.	15. U.S. has a strong labor sector with a high degree of organization and representation.	16. U.S. has a strong housing sector with a high degree of availability and affordability.
17. U.S. has a strong food sector with a high degree of production and distribution.	18. U.S. has a strong retail sector with a high degree of variety and quality.	19. U.S. has a strong services sector with a high degree of innovation and productivity.	20. U.S. has a strong government sector with a high degree of efficiency and effectiveness.

+++ Major Factor

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ABBT205051

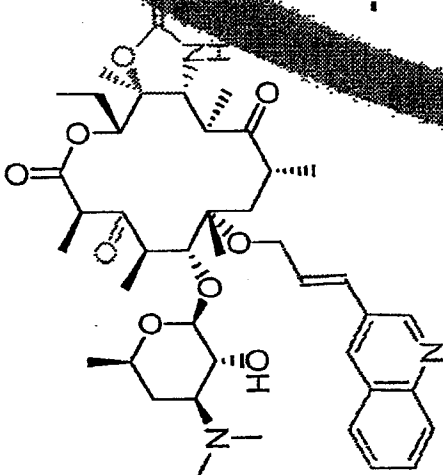
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ABBT205052

ABT-773 Ketolide

- Quinolylallyl propenyl moiety at the 6-O-position
- Keto group at the 3-position
- Carbamate group at the 11, 12-position



ABT-773

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ABB7205053

Deposition Exhibit 45

P's Exhibit IN

PART 2

ABT-773 Ketolide

- **Ketolides are a Novel Class of Antimicrobial**
- Active includes key respiratory tract infection pathogens including macrolide and penicillin resistant *S. pneumoniae* and *S. pyogenes*
- Bactericidal activity
- Prolongs lives antibiotic effect
- Reduced resistance development

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ABB7205054

Microbiology

MIC₉₀ µg/ml

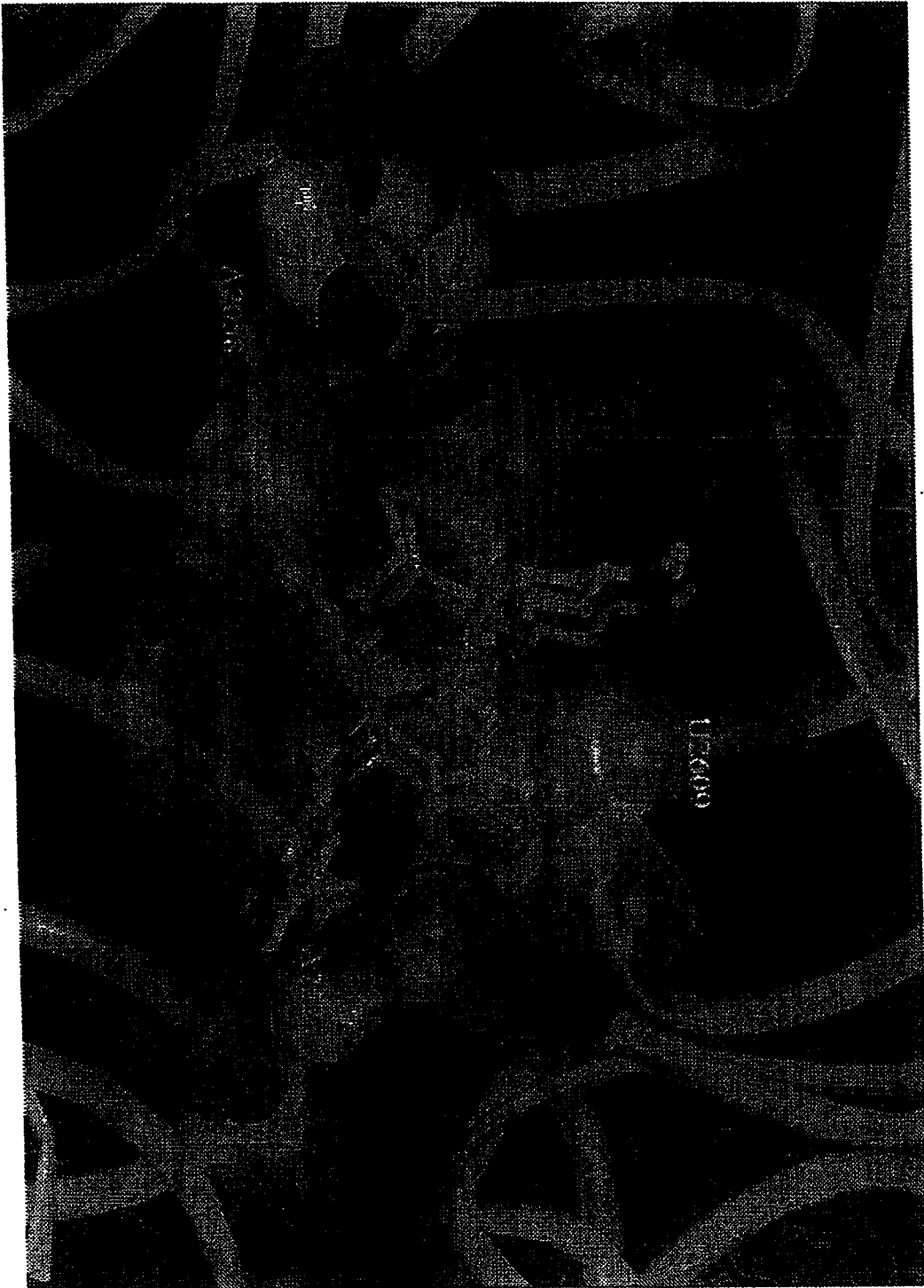
Organism	ABT-773	Ketek	Clari	Azi
<i>S. pneumoniae</i> ery-S	0.008	0.004	0.03	0.12
<i>S. pneumoniae</i> m1	0.12	1.0	4.0	16.0
<i>S. pneumoniae</i> epi	0.01	0.12	>32	>32
<i>S. pyogenes</i> ery-S	0.12	2.0	1.0	2.0
<i>S. pyogenes</i> ery-S	0.5	>8.0	>32	>32
<i>M. catarrhalis</i>	0.25	0.25	0.5	0.25
<i>H. influenzae</i>	2.0	2.0	16	2.0
<i>Legionella</i>	2.0	2.0	0.06	1.0
<i>M. pneumoniae</i>	<0.005	<0.005	0.008	<0.005
<i>C. pneumoniae</i>	0.015	0.06	0.06	0.12

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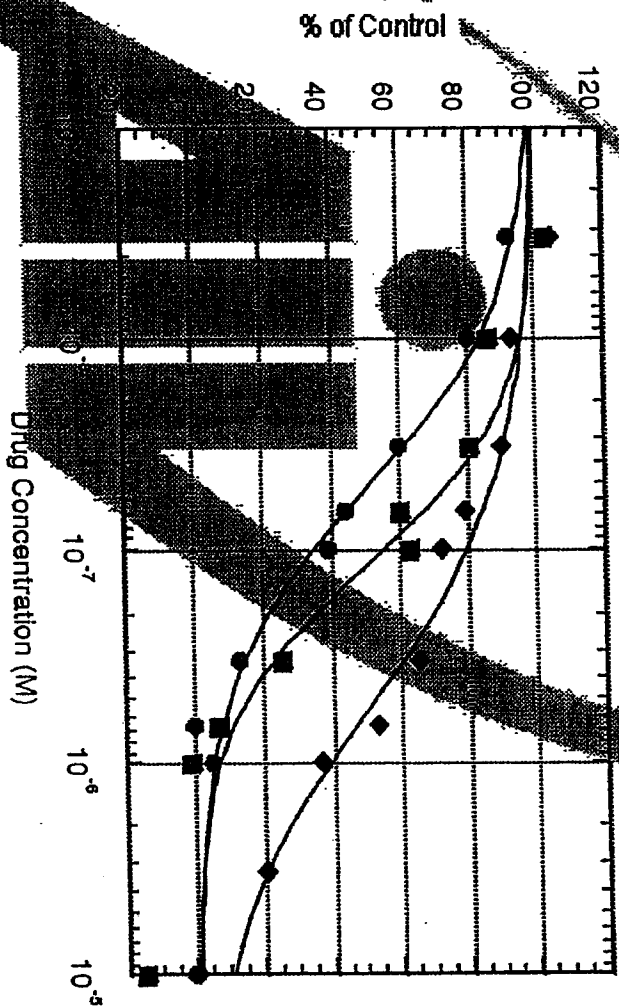
ABBT205055

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ABB1205056



Ribosome Binding, Susceptible *S. pneumoniae*



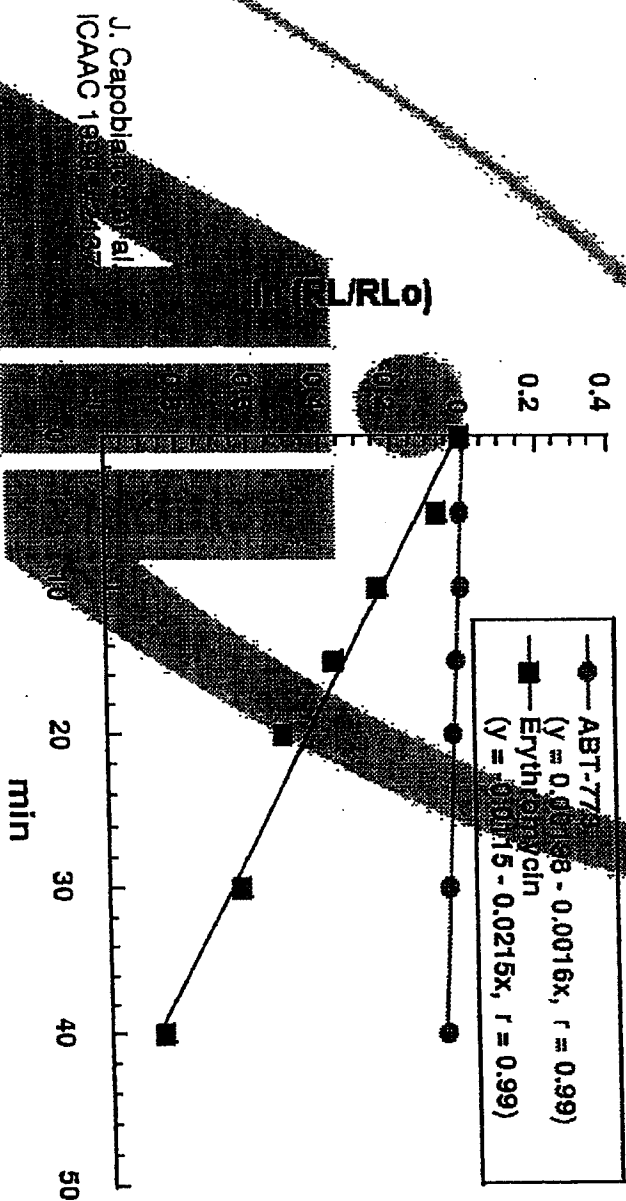
erythromycin (◆),
telithromycin (■),
ABT-773 (●).

IC₅₀ of Ery is 566
nM; telithromycin is
120 nM; ABT-773 is
52.7 nM. Abbott
Internal Data.

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ABB7205057

ABT-773 Displacement in Susceptible *S. pneumoniae* 2486



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ABBT205058

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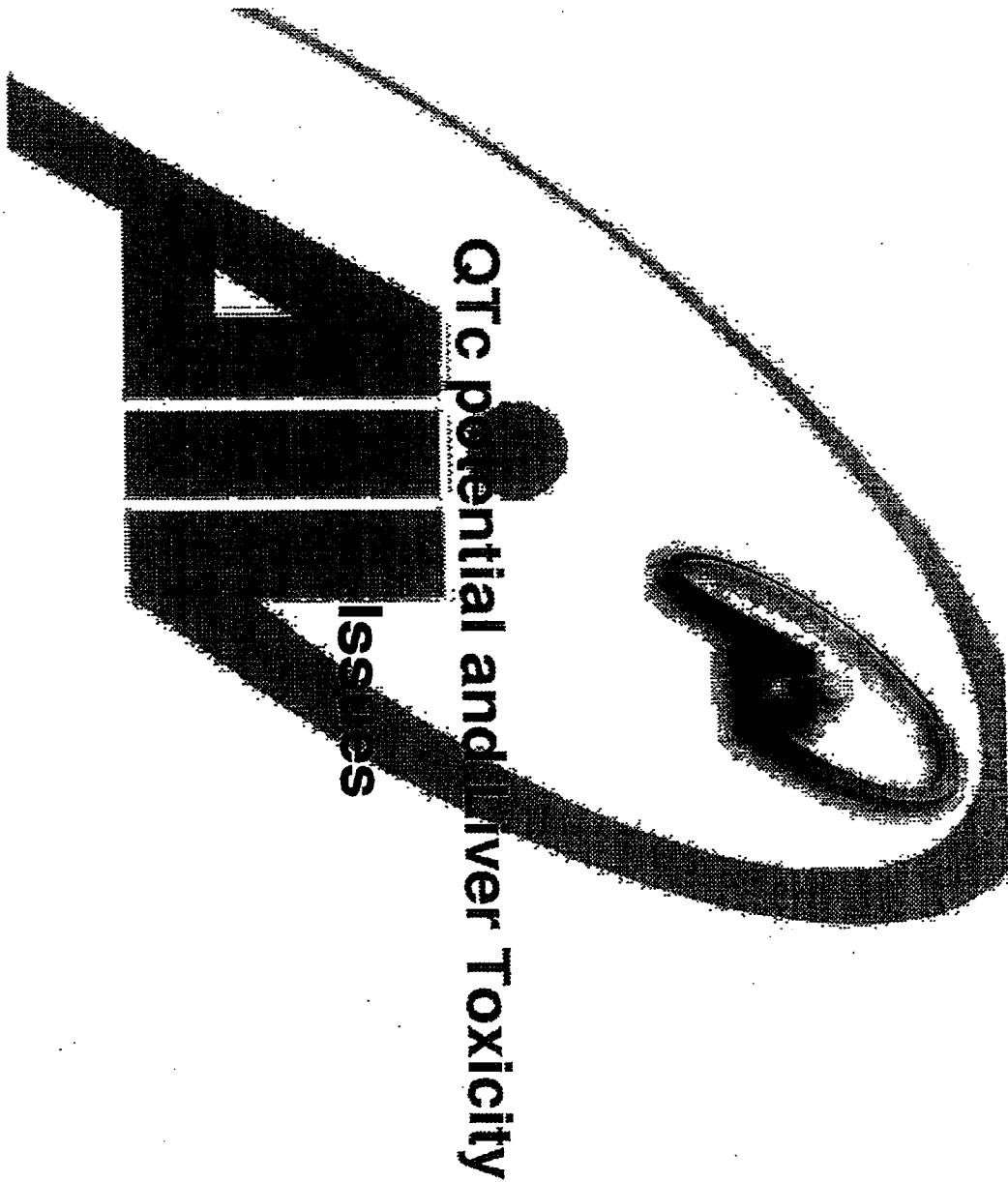


ABB1205059

QTc Prolongation Issues

- Potential for QTc Prolongation is a hot button worldwide
 - Antimicrobial agents including macrolides and quinolones are of concern to regulatory agencies
 - CPMR guidelines require data from animal models and 200 subjects
 - FDA is in the process of evaluating all drug class known to have a potential for prolonging QTc (erythromycin and clarithromycin)
 - FDA has question whether ketolides resemble like macrolides
 - FDA requires additional dog tox work to evaluate QTc
 - Required to include ECG monitoring in pivotal Phase 3 studies
 - FDA requires additional studies in patients with underlying cardiac disease
 - Some antimicrobials may contain warnings for QT prolongation
 - Health Canada like FDA data residing at FDA
 - Health Canada meeting rescheduled to May 2001 probably not related to QTc

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ABB7205060

Deposition Exhibit 45

P's Exhibit IN

PART 3

QT Prolongation Issues ABT-773

- Pre-clinical data positive for QTc dose response.
- A possible dose effect in Phase I at total daily dose ≥ 800 mg.
- No significant QT effect observed when ABT-773 was administered with the metabolic inhibitor ketoconazole. (Increased ABT-773 C_{max} 5X)
- No correlation response in Phase I studies (≤ 300 mg).
- No dose-related QT effect observed at clinical doses studied in Phase I studies (increasing QD to 600 mg QD)

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QTc Prolongation Issues ABT-773 Plan

- Completed pre-clinical evaluation of ABT-773
- Completed ECG monitoring of >200 patients in Phase II and III
- Continue to monitor QTc and electrolytes in Phase III programs.
- Planning FDA requested study of QTc in patients with pre-existing cardiac disease
- IV ABT-773 Phase III study will monitor QTc carefully
- Consult with Dr. Moegesser and Moss QTc advisors.

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ABBT205062

Liver Toxicity Issues

- Potential for liver toxicity is a concern for the FDA
 - Recent liver toxicity seen with Trovafloxacin are of concern to regulatory agencies.
 - Gemtioxacin recently not approved by FDA because of liver toxicity concerns.
 - FDA meeting on guidelines to industry on how to study liver function scheduled for February 11-12, 2001

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ABB1205063

Liver Toxicity Issues for ABT-773

- Preclinical tox showed some effect on the liver function.
- Japanese in bridging study showed increased LFTs.
- No evidence of LFT issue in Western subjects.
- No evidence of adverse response.

Repeat of Japanese bridging study in Japan showed No evidence of LFT increases in Japanese or Caucasians.

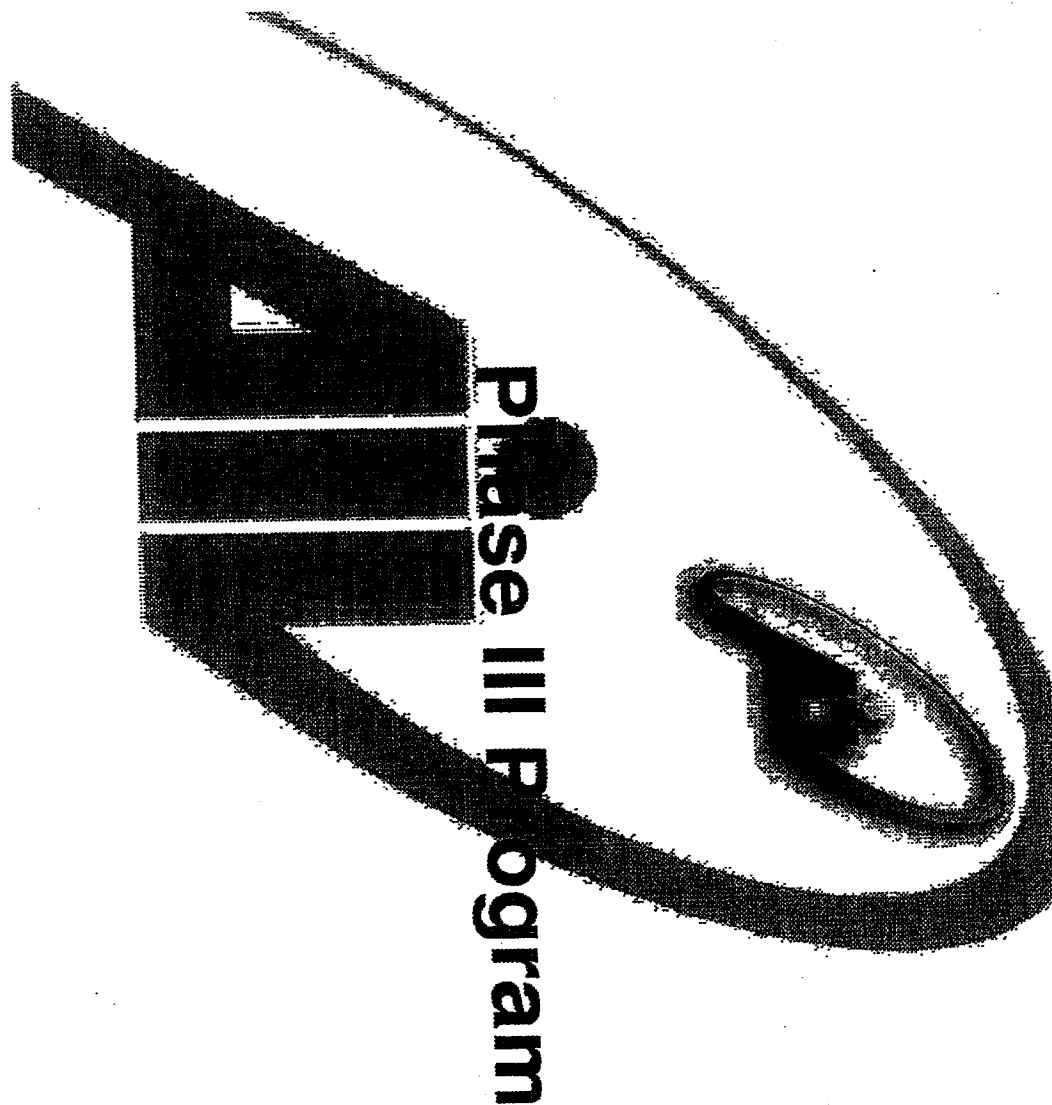
- ABT-773 plan to address problem

- Subject to review of LFT in Phase III programs.
can be well attended FDA meeting.

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ABB7205064

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ABBT205065

Phase III Program Proposed Indications and Treatment Duration

Infection	Dosage	Duration
Pharyngitis/Tonsillitis due to: <i>S. pyogenes</i> *	150 mg QD	5 d
Acute bacterial sinusitis due to: <i>H. influenzae</i> <i>M. catarrhalis</i> <i>S. pneumoniae</i> **	150 mg QD or BID 150 mg QD or BID 150 mg QD or BID	10 d 10 d 10 d
Acute bacterial exacerbation of chronic bronchitis due to: <i>H. influenzae</i> <i>M. catarrhalis</i>	150 mg 150 mg 150 mg	5 d 5 d 5 d
Streptococcal pharyngitis	150 mg QD or BID 150 mg QD or BID 150 mg QD or BID 150 mg QD or BID 150 mg QD or BID	10 d 10 d 10 d 10 d 10 d
Acute bacterial sinusitis due to resistant strains. Acute bacterial sinusitis due to macrolide-resistant strains.	150 mg QD or BID	10 d

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ABBT205066

Phase III Program Studies Started in Year 2000

Study	Indication	ABT-773 Regimen	Comparator	Number Subjects	Location
M00-223	Pharyngitis	150 mg QD 5 days	Penicillin V	185/520	US (IND)
M00-222	Pharyngitis	150 mg QD 5 days	Penicillin V	0/520	EU (Non-IND)
M00-216	Pharyngitis	150 mg QD 5 days	Azithromycin	131/600	US, Canada IND
M00-210	Pharyngitis	150 mg QD 5 days	Cefixime	0/500	EU (Non-IND)

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ABBT205067

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P's Exhibit IN

PART 4

Phase III Program Studies Started in Year 2000, Con't

Dose Finding Studies for Sinusitis/CAP:

Study	Indication	ABT-773 Regimen	Comparator	Number Subjects	Location
M00-225	Sinusitis	200 mg QD vs. 500 mg BID 10 days	None	137/500	US, EU (IND)
M00-219	Sinusitis	200 mg QD vs. 500 mg BID 10 days	None	76/500	US, Canada, EU (IND)

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ABBT205068

Dosing Issue 150 mg BID vs 150 mg QD Background

- Phase II data indicated 300 mg QD was not viable due to high levels of diarrhea (10-20%) and taste perversion (10-20%)
- Phase II ABECB and pharyngitis/tonsillitis data supported 150 mg QD
- 150 mg QD currently being evaluated in ongoing phase III trials in these indications

Dosing selection for CAP and sinusitis confounded by limited data

- few bacterial isolates, particularly without flu in sinusitis
- no placebo arm in CAP trial

- To increase probability of correct dose selection in CAP/sinusitis, the decision was made to undertake additional studies to generate more data on these indications

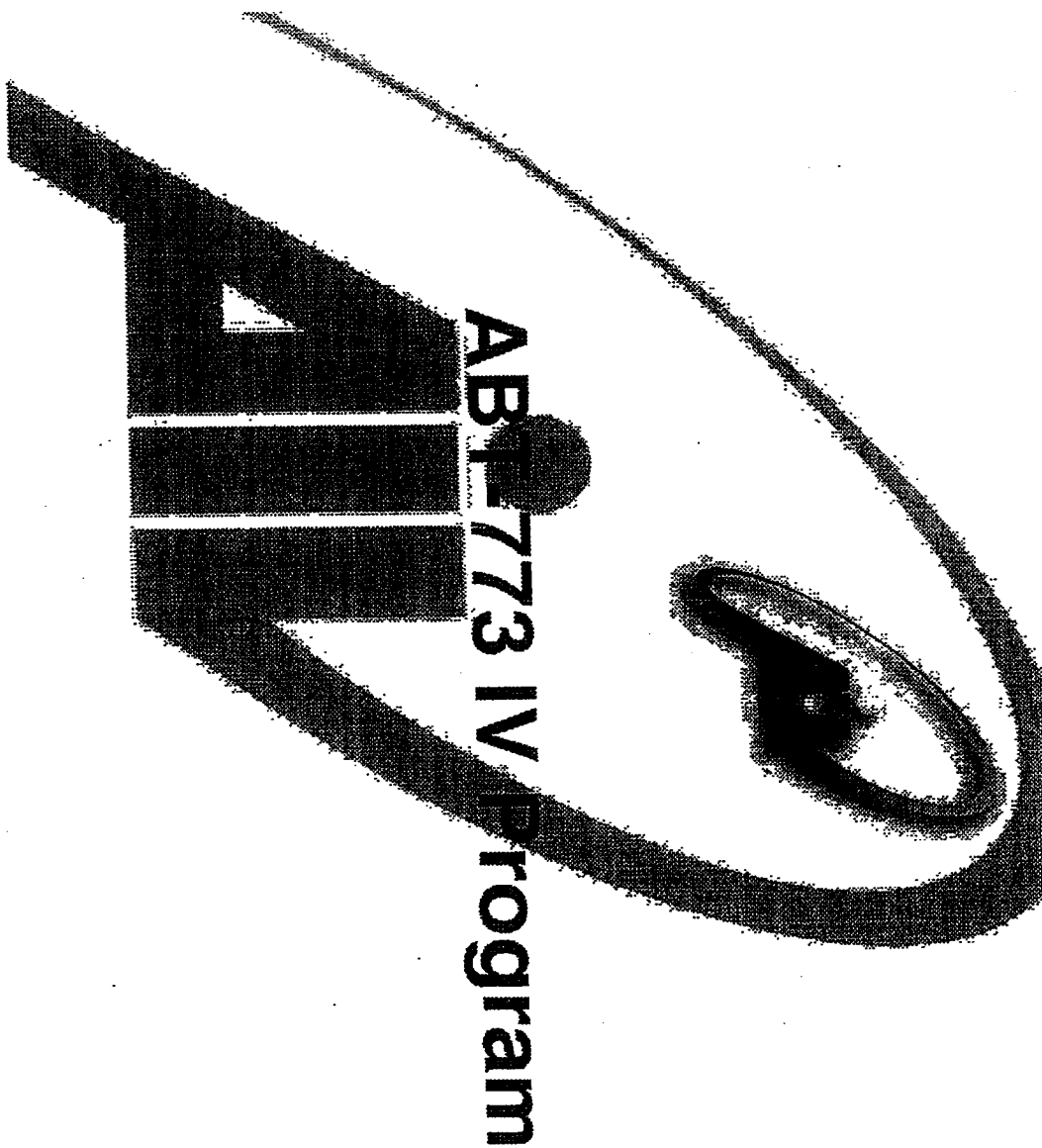
150 mg QD vs 150 mg BID CAP & sinusitis trials ongoing

150 mg QD vs 150 mg BID CAP & sinusitis trials ongoing

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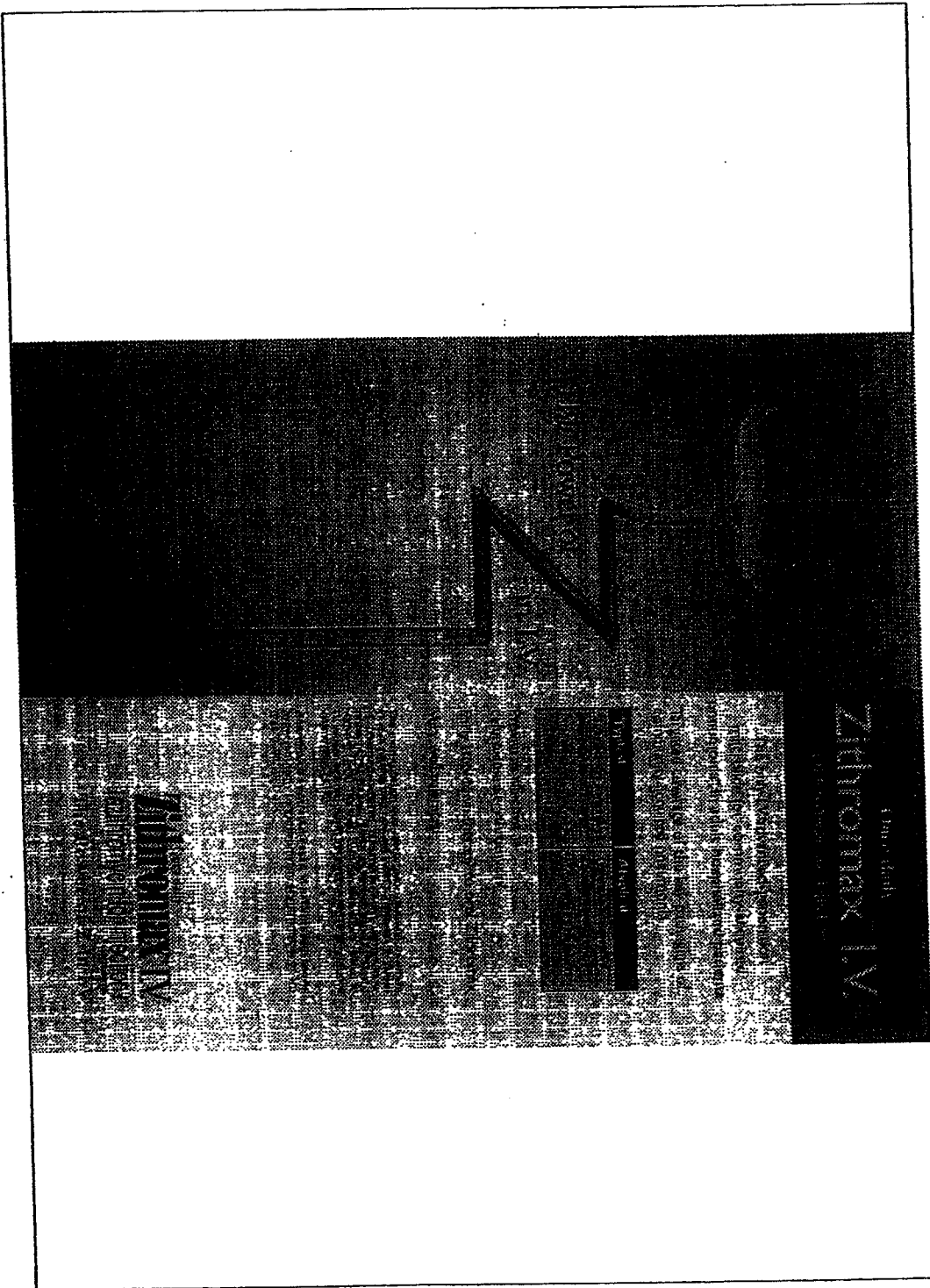
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ABBT205071

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ABB1205072



ABT-773 IV Formulation Strategic, Commercial, and Technical Value

Strategic Value

- IV represents a channel not currently served by Anti-Infective Franchise
- Leverages presence of Medical Center Reps and experience with ID community

Commercial Value

- IV availability figures favorably into decisions regarding formulary access to molecule
- potential advantage over telithromycin, which will not have an IV
- required to compete effectively with Zithromax, Teflaro, Avelex which have IVs
- Positive impact on tablet formulation
 - estimated to be incremental to peak tablet sales due to step-down therapy
 - Enhances overall "potency" image of brand

Technical Value

- Superior ~~to~~ ~~the~~ ~~existing~~ ~~resistance~~ ~~data~~ ~~in~~ ~~the~~ ~~market~~ ~~place~~ ~~will~~ ~~be~~ ~~important~~ ~~to~~ ~~establish~~ ~~body~~ ~~of~~ ~~evidence~~ ~~for~~ ~~this~~
- ~~the~~ ~~potential~~ ~~to~~ ~~reduce~~ ~~the~~ ~~potential~~ ~~value~~ ~~of~~ ~~the~~ ~~product~~ ~~by~~ ~~1~~ ~~year~~ ~~any~~ ~~of~~ ~~the~~ ~~above~~ ~~mentioned~~ ~~effects~~

IN addition, currently, the tablet launch by 1 year; any
technical value will reduce the potential value

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ABBT205073

ABT-773 IV Program Formulation Objectives

- Reconstituted solution . Once a day dosing. Low pain on injection
- Lyophilized powder, consisting of ABT-773 and a counter ion base.
- One strength in a flip-top vial and one ADD Vantage system at launch
- Dilute volumes: 100mL with length of infusion (30 to 60 minutes) and one of diluent (Dextrose 5% and/or normal saline) TBD based on animal pain models, clinical and stability studies.

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ABBT206074

ABB-773 IV Formulation PPD/HPD Funding Status

- PPD/HPD Collaboration Initiated 9/99
- PPD funded Program 01/00-08/00 (\$1.4MM)
 - Formulation development (lactate salt, lyophilized powder)
 - Animal pain models
 - Two week study (monkey)
- HPD funded Program 08/00-12/00 (\$0.8MM)
 - Two week study (rat)
 - Clinical supplies for Phase I
 - Small molecule
- 2000 - 2003 HPD response funding for 773 IV (\$7MM)
 - Milestone funding to Phase I Go/No Go (\$1MM)
- Total program development costs 2000 - 2003 (\$22.5MM)

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ABB7205075

Deposition Exhibit 45

P's Exhibit IN

PART 5

ABT-773 IV Formulation Animal Pain Study Results

- Assessed 6 prototypes (3 different counter ions at 2 pH levels) vs. clarithromycin IV and azithromycin IV
- Animal pain models showed no differentiation among all three compounds
 - Results not conclusive
 - Negative evaluation in humans
- Chose ABT-773 lactate as the prototype to test in Phase I studies based on formulation stability and stability.

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ABBT205076

ABT-773 IV Planned Clinical Program

With 2001 funding decision in Feb:

- Single Dose-rising Phase I study
- Multiple Dose Phase I with selected dose
- File US IND

- Initiate Phase II
 - 2 sites (Japan, CA) studies (US/Europe)

- 2 sites (Japan, CA) studies (US/Europe)
- 2 sites (Japan, CA) studies (US/Europe)
- 2 sites (Japan, CA) studies (US/Europe)

- Filing

Apr/01

June/01

Oct/01

Dec/01

Aug/03

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ABBT205077

ABT 773 IV Program Summary

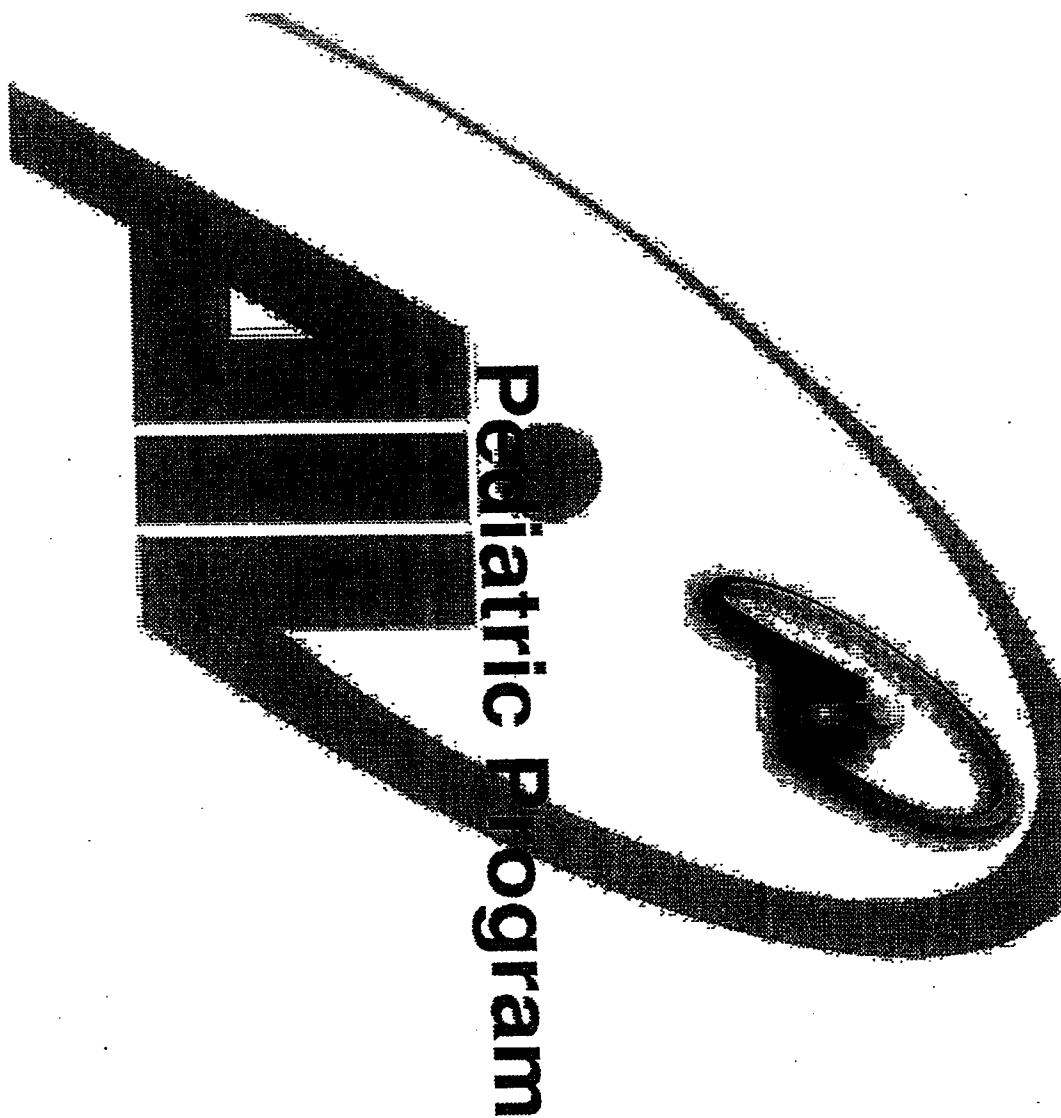
• Comments

- Funding for '01 not available PPD/HPD
- Go/No go could be made after Phase I based on safety profile (pain, QT, GI)
- Milestone funding recommended (\$1MM)
- Assembly purchased budget estimated \$7MM
- IV will be used to treat resistant *S. pneumo* claim
- Total Program Cost 2000-2003 (\$22.5MM)

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ABBT205078

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ABBT205079

ABT-773 Pediatric Formulation

Importance to the 773 program

- Increased perception of safety
- Better pricing and acceptance in European markets
- FDA requires studies in pediatrics

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ABB1205080

ABT 773 Pediatric Program Formulation Objectives

- Develop coated particle formulae for global use
 - coated particles for Suspension - 150mg/5mL & 300mg/5mL
 - coated particles as a dry syrup, sprinkle or sachet.
 - Desired Properties
 - Once a Day Dosing
 - Acceptable 'Initial Taste'
 - Minimal Aftertaste
 - No Unpleasant Mouthfeel
 - Acceptable Color and Flavor
- NO Refrigeration Required.

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ABBT205081

ABT-773 Pediatric Program Taste Assessment

Sensory Analysis of Uncoated Drugs Summary of Results

The three drug substances can be ranked from most to least bitter as follows:

ABT-773	0.79
Clarithromycin	4.2
Azithromycin	15

ABT-773 is approximately five times more bitter than clarithromycin

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ABB7205082

Deposition Exhibit 45

P's Exhibit IN

PART 6

ABT-773 Pediatric Program Taste Assessment

- The ABT-773 encapsulated prototype #2 may be at risk of dosing compliance problems due to flavor quality.
- Overall ABT-773 Prototype 2
 - Less bitter than Biaxin both initial and after taste
 - More bitter than Zimmax both initial and after taste
- For ABT-773 Prototype 2, the flavoring aromatics and sweeteners delay quickly exposing the bitterness which lingers throughout the aftertaste at or above the sensitivity level.

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ABBT205063

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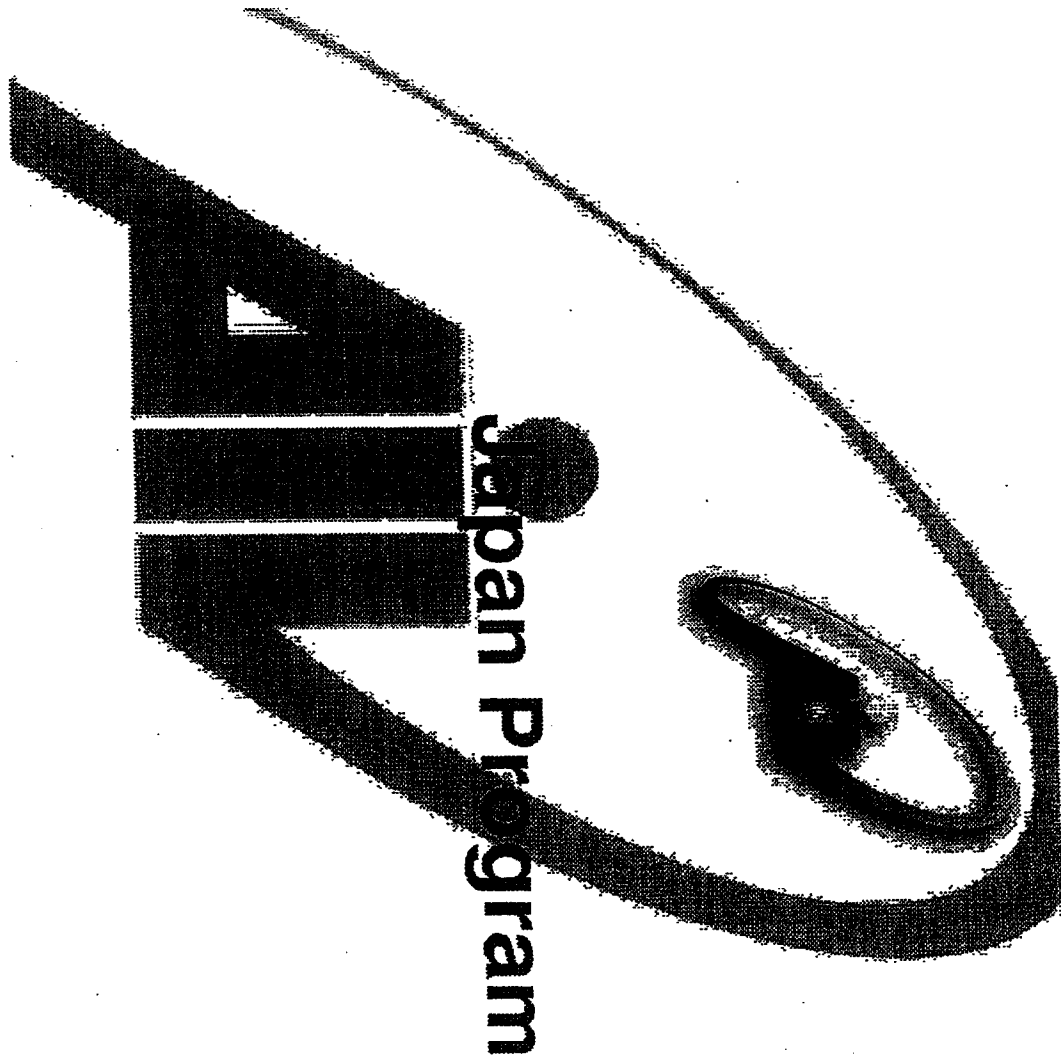


ABB1205084

Japan Program Taisho

- Japan development is planned in coordination with Taisho and Dainabot
- Meetings are held at least 3 times a year to review developments
- Taisho funds 100% of global development costs and 50% of local Japan costs
- Bridging strategies primary plan for development in Japan

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ABBT205085

Japan Program Clinical Plan

- Phase I in Japan
 - Food Effect Study
 - Single and multiple dose study
 - Review data (Abbott/Taisho)
 - PK data in Japanese vs Caucasian
 - Based on program strategy
 - Phase II in Japan and recommend development program
 - Food Effect Study
- 2Q/01

April/01

Completed

Start
Completed

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ABB7205086

Japan Program Clinical Plan

- PK similar in Japanese and Caucasians (12/02 filing)
 - Recommend to Kiko same dose in Japan as in ex-Japan
 - Recommend to Kiko one comparative bridging study in CAP (Phase III) and several smaller local studies in skin infections, dentistry, otitis/otolaryngology, UTI and pan-bronchiolitis
 - Taisho agreement necessary prior to Kiko meeting
- PK difference in Japanese and Caucasians (12/03 filing)
 - Phase III dose-bridging study in CAP (Bridging study)
 - Phase III comparative study will be required
 - Funding open on 11/22/03
 - Discussions on Taisho cost-sharing

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ABB1205087

Deposition Exhibit 48

P's Exhibit JO



From: Jeff Leiden
John Leonard

INTEROFFICE CORRESPONDENCE

TO: Miles White

Date: Jan. 7, 2002

CC:

Bill Dempsey
Dave Goffredo
Mary Szela
Jim Tyree
Eugene Sun
Stan Bukofzer

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RE:

On December 10th, the Pharmaceutical Executive Committee met to review the development status of ABT-773, our ketolide antibiotic in clinical development for respiratory tract infections. Based on the data reviewed at the meeting, the Committee recommends suspending further development and initiating efforts to out license the compound. Attached is a package, which addresses the key issues. Our decision for this recommendation is based on the following:

1. Divergence from the target product profile

ABT-773 was approved for clinical development in a March 1997 Drug Development Committee (PPCC), at which time the key elements of the target product profile were defined as:

- ♦ Once daily dosing for short course treatment regimens (5-10 days)
- ♦ Favorable side effect profile relative to currently available therapies
- ♦ Efficacy against major respiratory pathogens, particularly against resistant organisms, a key differentiating feature of this compound
- ♦ Once daily dosing has not been achieved in 3 of 4 respiratory indications:
 - ♦ In July 2001, twice daily dosing was chosen for the pivotal Phase III clinical trials in sinusitis and community acquired pneumonia. This decision was taken based on accumulated scientific data and to enhance regulatory approvability of the compound, but recognized a corresponding decrease in the commercial value; particularly given the global trend toward once-a-day/shorter course therapy.
 - ♦ In November, the pivotal U.S. Phase III trial in pharyngitis showed that ABT-773 dosed once daily at the chosen dose had insufficient efficacy for approval. Additionally, these results cast some doubt on the potential for QD dosing for bronchitis.

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ABBT0559668

Leiden EXHIBIT *48*
FOR 1/4-26-07 1 JAK

- ♦ The emerging side effect profile of ABT-773 is neither significantly better nor worse than clarithromycin in terms of taste and the potential for drug-drug interactions. There are still safety issues that remain to be better defined, i.e., the potential for QT prolongation, and the incidence and severity of liver enzyme abnormalities (see #3 below).
 - ♦ A resistance claim, which is a key point of commercial differentiation, will be challenging to achieve:
 - ♦ The resistance claim is based on successful treatment of pneumonia patients who have resistant organisms. The original ABT-773 plan targeted approximately 15 such patients. In 2001, the EMEA and FDA evaluated telithromycin (Ketek), Aventis' first-in-class ketolide. Neither the EMEA nor FDA considered the Ketek data sufficient to support a resistance claim based on 17 patients with about an 85% eradication rate. It is now anticipated that a resistance claim for ABT-773 will require a larger number of resistant isolates (this requirement will significantly increase the size, complexity, and duration of clinical trials) as well as an eradication rate of at least 85%.
2. Increasing regulatory stringency
- ♦ Regulatory approval of new antibiotics is increasingly dependent on their benefit:risk ratio compared to currently available therapies. Given that most respiratory antibiotics have greater than 85% success rates there is increasing attention to drug safety. Although Ketek was approved by EMEA this year, significant post approval commitments were mandated, i.e., additional safety data in over 4000 patients. In the US, Aventis has been asked to obtain additional safety data prior to FDA approval. Given that some of the same safety issues may apply to ABT-773, the projected size of the required safety database for ABT-773 has increased considerably. This will increase the expense and duration of the phase III trials.
 - ♦ Regulatory authorities are increasingly concerned about widespread antibiotic resistance resulting from inappropriate antibiotic usage. They are considering ways to curb indiscriminate antibiotic usage, such as limiting regulatory approval for indications that do not always warrant antibiotic therapy, e.g., acute exacerbation of chronic bronchitis. This indication represents one of the largest respiratory market segments.
3. Unresolved potential safety issues
- ♦ QT prolongation by ABT-773 has not been fully characterized and remains a potential liability. In recent years, broad regulatory attention to this issue has resulted in increasing requirements for *in vitro* as well as clinical data to assess this risk. To date, data indicates that QT prolongation by ABT-773 is comparable to that of clarithromycin and Ketek, but FDA has requested additional studies. Should these studies suggest clinically significant risk, regulatory actions could include non-approval, Black Box warning, or contraindication in at-risk populations.

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- ◆ Significant liver enzyme elevations have been observed in a few subjects in clinical trials to date, most recently in a study to evaluate QT prolongation. Clinical protocols have been modified to increase patient monitoring, leading to increased clinical costs and a delay in filing. Although the incidence and severity of these findings fall within an acceptable range for antibiotics, future findings may drive the requirement for a larger safety database.
- 4. **Decreased commercial valuation**
 - ◆ The loss of the pharyngitis indication is forecasted to erode more than \$117MM in NPV from ABT-773 (-\$82MM AI; -\$35MM PPD). Based on the above information, the global NPV of ABT-773 falls from a July 2001 \$223MM to \$51MM with the U.S. market NPV largely break-even at \$3MM and Abbott International contributing the balance of value.
 - ◆ In addition, if the regulatory authorities require additional patients to evaluate safety, the value of ABT-773 becomes negative.

Attached are several slides that provide additional detail to the issues discussed above. Obviously we are extremely disappointed to recommend stopping a key phase III program in development. However, at this time, the team recommends placing development on hold and redirecting R & D funds to higher return opportunities. If this decision is made shortly, the team forecasts that it would create a 2002 R&D favorability of approximately \$47MM.

Next Steps

We look forward to meet with you regarding our recommendation and to secure your approval to move forward with the decision to place clinical development on hold. If approved, the next steps will include:

- ◆ The preparation of an internal and external communication package for all stakeholders paying particular attention to PR issues and timing of the process.
- ◆ Communicating with Taisho. As you are aware, the development of ABT-773 has been conducted in collaboration with Taisho under a 1997 Agreement in which Taisho contributes 50% of the Japanese development cost and 10.69% of the ex-Japan expenses. Abbott has the right to out license the compound outside Japan without Taisho's consent, but the royalty obligations remain in effect (5.5% in patented territories and 2.75% in non-patented countries). Sub-licensing of Abbott's rights in Japan is allowed only after Taisho's consent.
- ◆ The PEC believes that the compound may hold potential for out licensing. To capture value for ABT-773 an out licensing effort, which might include follow-on compounds already in discovery, would be aggressively initiated.

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Deposition Exhibit 52

P's Exhibit JT



Stan
Bukofzer/LAKE/PPRD/ABBO
TT
02/09/2002 03:20 PM

To Jeff M Leiden/LAKE/CORP/ABBOTT@ABBOTT
John Leonard, William Dempsey, William Dempsey, James
L Tyree/LAKE/GPRD/ABBOTT@ABBOTT, Eugene Sun,
cc Bryan A Ford/LAKE/PPRD/ABBOTT@ABBOTT, Jill
Mueller/LAKE/PPRD/ABBOTT@ABBOTT, Michael B
Spengler/LAKE/PPRD/ABBOTT@ABBOTT
bcc
Subject ABT 773 documents requested

Jeff

As requested before your trip, I am attaching ABT 773 communication plan and headcount reallocation assessment document for your review

1. The communication plan has been developed with public affairs departments, investor relations and HR delivers a consistent message to all audiences involved

- ◆ Taisho has formally agreed with the communication
- ◆ Your request that we specifically emphasize no Abbott employee will be affected from a job perspective needs to be discussed further (see below).
- ◆ As agreed I have already let the VP level of the affected CROs know that the trials are on hold and the message was well received, but please note that charges continue to accrue until the message can be devolved into their organizations

2. The timing of the communication rollout is attached as a separate document with Day1 TBD by yourself

3. The second document summarizes the absorption of headcount from nearly 50 departments working on ABT 773. It was created working closely with GPRD operations, human resources and finance departments

- ◆ It includes regulatory requirement of IND update by April, limited CMC activity, but sufficient to support whatever decision is made in April and 6 months of stability work to allow for time to potentially out-license the product. Clinical program includes full reports on all trials, but QA of only 10% of sites. QT trial to be completed, but it will not be sufficient for FDA requirements. Additional trial contingent would cost \$1-2MM, but is not budgeted. All trials have ECG reports, but with a few exceptions, will not have analysis of digital overreads that have been performed. (data is available for later use).

- ◆ We identified by department the number of individuals involved, and feel confident that for almost all departments, the existing projects' workload, and the existing approved open headcount requisitions will make placement/absorption easy.

- ◆ The exceptions are PARD formulation and analytical chemistry area, Discovery microbiology and process chemistry, where changes to the company structure (Chicago vs. Ludwigshaven), full capacity utilization and specific skill sets of the people might present a challenge to reassignment. A more detailed discussion with managers is needed and is reflected in the timelines. At this time the exact number of people could be assessed (probably about 20 people.)

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Leiden EXHIBIT 52
FOR ID. 4-26-07 JAL

I am available anytime this weekend if you wish to discuss before Monday
My contact numbers are mobile 847-757-3447 and home 847-955-0627.
Stan



FINAL COMMUNICATION STRATEGY COMMUNICATIONS ROLL OUT TIMELINE Final.



773Dept HC rollout final.xl

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PHASE I COMMUNICATIONS ROLL OUT TIMELINE

ACTIVITY BY AUDIENCE	TIMING	MODULE	RESPONSIBILITY
Meeting with E. Shek, S.Chang, (determine specific messages for key depts.)	2/11-13/02	N/A	Bukofzer, Spengler, Sun
Meeting with PARD/Discovery Managers (determine needs)	Day One -- morning	Module III	Bukofzer, Shek, Chang, Spengler, Managers
Meeting with Core Venture	Day Two -- morning	Module III	Bukofzer, Spengler
Meeting with Discovery (specific areas affected)	Day Two -- morning	Module III	Cheng, Spengler, (Bukofzer)
Meeting with PARD (specific areas affected)	Day Two -- morning	Module III	Shek, Spengler, (Bukofzer)
Core ABT-773 Team (all functional areas)	Day Two -- afternoon	Module III	Bukofzer, Spengler
Meeting with Mary Szela (Sales/Marketing Directors)	2/11/02	N/A	Szela, PPD, PA, Bukofzer, Sun
Communications to Sales Force (U.S. Only)	Day Two -- morning	Module V	Szela/Sales Directors/RMs
AI Area VPs	2/11-2/13/02	Module IV	AI, PA, Bukofzer, Sun
AI GMs	Day One -- TBD	Module IV	AI VPs
ECO Directors; medical directors (Greece, France, Germany, UK, Spain)	Day One--morning	Module IV	Bukofzer
Abbott European functional project teams, including med dir with trials	Day Two-- morning		Bukofzer, HR-TBD
Other AI medical directors	Day Two -- TBD	Module IV	AI GMs
Advisors/Opinion leaders	Day Three	Module VI	Bukofzer/Venture
Phase III Investigators (ethics committees/IRBs via U.S. investigators)	Day Three-Five	Module VI	Bukofzer/Venture
CROs (Initial VP level only)	Complete -- 2/5-2/8/02	Module I	Bukofzer
CROs (Second Notification, letter)	Day Two	Module I	Bukofzer
Media/Investment Community	As necessary	Module II	PA/IR
Other External vendors	Day Five, sooner if possible	Module VII	Venture
Dianabbot/Taiho Meeting	2/18-2/19/02	Module I	Bukofzer, team
Regulatory Agencies	As necessary	Module VIII	Welch, Boynton/Venture/CRO

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**ABT-773 Global Communications Plan
PHASE I**

Situational Analysis

ABT-773 belongs to the ketolide class of antibiotics, which was developed to treat macrolide resistant organisms in community respiratory tract infections. However, since development was started on ABT-773, the newer quinolone class of antibiotics has specifically targeted macrolide resistant respiratory organisms, thereby reducing the unmet medical need that existed.

The product profile envisaged at the start of the development program included once-daily dosing for short periods (5-10 days) for all the common respiratory outpatient indications. This profile was considered highly competitive with other products on the market. During development the product profile changed such that it no longer met these criteria.

Aventis' new ketolide antibiotic, Ketek, underwent significant regulatory scrutiny during 2001. In Europe, further data was required to support the efficacy claim of treating macrolide resistant respiratory organisms and in the United States additional data was requested to ensure that it had no QT or liver safety concern. ABT-773, could receive similar regulatory scrutiny. Overall, it is felt that there is no data generated to date that would exclude ABT-773 from obtaining regulatory approval, but the cost and timeline to achieve that have changed.

As a result of the above circumstances, ABT-773, while likely approvable, has reduced commercial attractiveness to Abbott, when compared to other opportunities at this time. It might however, fit another company's commercial needs.

In view of the above Abbott is considering its alternatives regarding EU and U.S. development (eg. out-license). The development of the drug for Japan (and the Japanese rim) needs specific consideration given the partnership that exists with Taisho and the fact that the current profile of the drug is highly acceptable in the Japanese market.

Communication will be in two phases. All messages, both external and internal will be consistent. The first phase of communication is described below. The second phase of communication will commence in April. All communications plans were reviewed and approved by Taisho during the week of 2/4.

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Objective:

- To effectively and consistently update internal and external stakeholders regarding the delay of ABT-773 Phase III clinical trials.

Strategies:

- Ensure consistent communication of all key messages regarding the delay of ABT-773 Phase III clinical trials across all audiences.

Core Key Messages: All Audiences*

- ABT-773 Phase III clinical program has been delayed as a result of a changing regulatory environment. [If asked: could delay timeline by one year].
- The FDA continues to reassess the safety requirements of anti-infectives, specifically ketolides. Given the scrutiny, which Ketek underwent, Abbott was proactive in discussions with FDA regarding QT data needed for ABT 773 approval. We do not expect QT to be an issue with ABT-773.
- At this time, since we have missed most of this respiratory season, our Phase 3 trials will be delayed. Therefore, it is prudent to have the QT study completed before we move forward with the new Phase III trials. We continue to collect data from our ongoing trials..
- In order to optimize time utilization, responsibilities of employees currently working on ABT-773 may be shifted as a result. Every employee affected will have a new role on a different project. In line with our strategy of our global R&D organization and to maximize the development of our other compounds in clinical trials, employees will be redeployed based on the experience and interest of each employee.

** [To discuss sentence "every employee." Tailored Messages for PARD and Discovery employees to be determined in 2/11 meeting with Bukofzer, Chang and Shek]*

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CRO COMMUNICATIONS (3 IN TOTAL) – MODULE I

Timing: Complete

Communications vehicles: Telephone conversation between Stan and senior level (VP) contact at three CROs involved in Phase III clinical trials.

Rationale: Due to contractual obligations, Abbott needs to communicate that Phase III clinical trials have been delayed. Charges continue until they are able to mention it to their employees.

Messages: Core Key Messages and Talking Points

Talking Points:

- I know you are interested in Abbott's plans for Phase III development of ABT-773.
- I want to reinforce that under contract, our business plans are completely confidential. If that confidence were broken, further business with Abbott and its clinical trials would be impacted.
- ABT-773 Phase III clinical trials have been delayed as a result of a changing regulatory environment. [If asked: could delay timeline by one year].
- At this time, since we have missed most of this respiratory season, our trials will be delayed. We do not expect QT to be an issue with ABT-773. However, it is prudent to have the QT study completed before we move forward with the Phase III trials.
- We will extend letter of credit for 2 more weeks, up until 2/18/02, so that we will honor costs incurred until then. However, please minimize these costs. We do not want you to contact your own managers/CRAs as this will preempt our communication (Stan/Ann Hubloux to implement)
 - [PPD –will probably want S. African sites for CAP for 492,
 - Paraxel –key for us to get study M00-219 complete by March and will need continued help. (We have already indicated that the data is really dirty and is an issue)
 - Phoenix – we will want to use the same team for the 492 trial so no losses at all.]
- Please do not share this information with other Abbott employees working on this project, or others in your organization. Immediately cease contact with Abbott until we are able to communicate this change internally.
- I will update you in the future once we have determined the development timeline of ABT-773.

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MEDIA/FINANCIAL COMMUNITY COMMUNICATIONS – MODULE II

Timing: Immediate preparation and ongoing as appropriate

Communications vehicle: Response document for use with investor community and media.

Rationale: To respond to potential questions regarding delay of ABT-773 development.

Messages: Use Core Key Messages and Response Document

Talking Points:

- ABT-773 Phase III clinical trials have been delayed as a result of the changing regulatory environment.
- Based on the timing required to reflect these needs in the new trials, we recognize we have missed the peak of the 2002 respiratory season.
- We hope to provide further guidance on 773 for the coming months and will continue to update you as we can.

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EMPLOYEE COMMUNICATIONS – MODULE III

Timing: Day One, Ongoing

Communications vehicles:

- Meeting with R&D Managers
- Separate employee meetings with Development, and specific departments in PARD and Discovery
- Meeting with Core team (Reps from most of 49 departments involved in ABT-773)

[These meetings will take place after "ABT-773 Employee Road Map" has been approved by J.Leiden.]

Rationale: To ensure consistent communication throughout entire organization, as well as quell fears of employees and job security.

Messages: Use Core Key Messages and Talking Points

[Tailored Messages for PARD and Discovery employees to be determined in 2/11-13 meeting with Bukofzer, Chang and Shek]

Talking Points:

- I'd like to bring you up to speed on the status of our Phase III development program for ABT-773 – at the present time we are planning to delay certain Phase III clinical trials.
- As you all know, the FDA continues to reassess the safety requirements of clinical trials of anti-infectives, specifically ketolides. Abbott is taking into consideration concerns regarding QT with the ketolide class and is conducting a QT study. Additionally, we are waiting on analysis of additional Phase III data.
- At this time, since we have missed most of this respiratory season, our trials will be delayed. We do not expect QT to be an issue with ABT-773. However, it is prudent to have the QT study completed before we move forward with the Phase III trials.
- And, as we've missed the respiratory season this year, our development timeline has obviously been delayed. We should have a better idea of our plans for ABT-773 after QT data come back in the early spring.
- Therefore, to optimize use of your time, responsibilities for some of you will be shifted in order to use your skills and experiences on a number of exciting projects including [insert project examples here] in GPRD that need additional resources.
- **[IF APPROPRIATE]** I want to be very clear on one point – no one will be losing his or her job. **(TBD)** In fact, our new GPRD organization enables us to be more flexible, supporting the projects that are funded and moving forward quickly. Discovery and development projects are cyclical – they slow down, ramp up, start up, are delayed, and are stopped all the time. Flexibility to take over other responsibilities will, in fact, equal job security for all of us.
- We've reviewed the job responsibilities in detail and have a complete plan to move you onto other projects. Your managers will explain each plan in detail with you.
- As with all our development programs here at Abbott, I want to reinforce the fact that details on the development of any of our projects must be kept confidential.
- I welcome any questions you have regarding this change. Please feel free to call me to speak about it or talk with your manager.

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AI AFFILIATE COMMUNICATIONS – MODULE IV

Timing: Day One, Two

Communications vehicles:

- *Inform AI Area VPs*
- *VPs Inform GMS.*
- *Teleconference with ECO, medical directors in countries where there are clinical trials (30 affiliates)*
- *Teleconference with AI Medical Directors and functional project teams*

Rationale: To ensure consistent communication throughout entire international organization, update affiliates on the status ABT-773 development and give affiliates the appropriate messages to communicate to clinical trial investigators/sites and other external audiences.

Messages: Refer to Core Messages and Talking Points

Talking Points:

- *I'd like to bring you up to speed on the status of our Phase III development program for ABT-773 – at the present time Phase III clinical trials have been delayed.*
- *The FDA continues to reassess the safety requirements of clinical trials of anti-infectives, specifically ketolides. Abbott is taking into consideration concerns regarding QT with the ketolide class and is conducting a QT study.*
- *At this time, since we have missed most of this respiratory season, our trials will be delayed. We do not expect QT to be an issue with ABT-773. However, it is prudent to have the QT study completed before we move forward with the Phase III trials. We continue to collect data from our ongoing trials.*
- *Please communicate this change to the sites in your area, as appropriate; we've created some key talking points for your aid in communications.*
- *As always, I want to remind you that our information regarding our development programs remain confidential.*

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U.S. AI/GI SALES FORCE COMMUNICATIONS – MODULE V

Timing: Day Two

Communications vehicles:

- *Conference call with AI/GI Sales Directors and Regional Managers. (There are 1,500 U.S. investigators involved in Phase III clinical trials)*
- *District Conference calls with representatives.*

Rationale: To ensure sales representatives are aware that Phase III trials have been delayed, as well as prepare representatives with a response to use with investigators if asked.

Messages: Refer to Core Messages and Talking Points

Talking Points:

- I'd like to bring you up to speed on the status of our Phase III development program for ABT-773, our advanced-generation ketolide. At the present time, Phase III clinical trials have been delayed.
- The FDA continues to reassess the safety requirements of clinical trials of anti-infectives, specifically ketolides. Abbott is taking into consideration concerns regarding QT with the ketolide class and is conducting a QT study. [You're probably aware of the scrutiny that Aventis has been under regarding Ketek's trials].
- At this time, since we have missed most of this respiratory season, our trials will be delayed. We do not expect QT to be an issue with ABT-773. However, it is prudent to have the QT study completed before we move forward with the Phase III trials. We continue to collect and analyse data from our ongoing trials.
- We wanted you to be aware of this in case investigators ask about the status. **Please instruct representatives to only respond to the investigator's inquiry and to not proactively give out information regarding our trials.** Investigators with specific questions can be referred to Stan Bukofzer at 1-847-9550627
- As with anything regarding our development programs, I want to reinforce the fact that details of the development of any of our project need to be kept confidential.
- Though Phase III trials are currently delayed, I want to assure you that as a corporation, we are still very committed to our Anti-Infectives business and its future. I will keep you posted on additional information regarding ABT-773.

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**PHASE III INVESTIGATORS, (IRBs, ETHICS COMMITTEES VIA
INVESTIGATORS), NATIONAL ADVISORS, OPINION LEADERS
COMMUNICATIONS – MODULE VI**

Timing: Day Three-Five

Communications vehicles:

- Letter from Abbott to all investigators who will not be commencing Phase III trials and who are waiting to hear from us with a follow-up phone conversation as appropriate. This letter would include information that investigators should pass on to ethics committees/IRBs. Provide template letter.
- Phone conversation with national advisors.
- Phone conversation with opinion leaders.
- All Medical Directors to contact International Investigators/sites

Rationale: To consistently update all investigators, national advisors, opinion leaders and ethics committee members on the status of ABT-773 development.

Messages: Use Core Key Messages, Talking Points and mail attached letters to investigators

Talking Points:

- I'm calling regarding the status of our Phase III development program for ABT-773. At the present time Phase III clinical trials have been delayed. [For investigators receiving letter: I know you are aware of this based on the letter you received].
- The FDA continues to reassess the safety requirements of clinical trials of anti-infectives, specifically ketolides. Abbott has been proactive in taking into consideration concerns regarding QT with the ketolide class and is conducting a QT study.
- At this time, since we have missed most of this respiratory season, our trials will be delayed. We do not expect QT to be an issue with ABT-773. However, it is prudent to have the QT study completed before we move forward with the Phase III trials. We continue to collect data from our ongoing trials.
- I will be sure to follow up with you via letter and/or phone once the development timeline for ABT-773 has been determined. [If asked specifically: the timeline for ABT-773 has been pushed back one year].
- Remind of Confidentiality Agreement.

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EXTERNAL VENDORS – MODULE VII

Timing: Day Three-Five

Communications vehicles: Telephone conversation and/or letter from Venture to external vendors.

Rationale: Communicate to vendors that we no longer need their services at this time to assist with certain new Phase III clinical trial/ Phase I studies.

Messages: Core Key Messages and Talking Points

Talking Points:

- At this time, Abbott has decided to delay ABT-773 Phase III clinical trials development. Abbott will complete the Phase III trials that are currently underway. However, we will not be starting any additional trials at this time.
- The FDA continues to reassess the safety requirements of clinical trials of anti-infectives, specifically ketolides. Abbott is taking into consideration concerns regarding QT with the ketolide class and is conducting a QT study. Additionally, we are waiting on analysis of additional Phase III data.
- At this time, since we have missed most of this respiratory season, our trials will be delayed. We do not expect QT to be an issue with ABT-773. However, it is prudent to have the QT study completed before we move forward with the Phase III trials.
- I want to reinforce that under contract, our business plans are completely confidential. If that confidence were broken, further business with Abbott and its clinical trials would be impacted.
- I will update you in the future once we have determined the development timeline of ABT-773.

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REGULATORY AGENCIES COMMUNICATIONS – MODULE VIII

Timing: As Necessary

Communications vehicle: Communication via letter or telephone conversations (which ever are appropriate) with external regulatory agencies and PPD/AI Regulatory Affairs. To be completed only if required.

Rationale: To update regulatory agencies on the status of ABT-773 development.

Messages: Use Core Key Messages and Talking Points

Talking Points:

- I'd like to update you on the status of Phase III clinical development. Phase III clinical trials will be delayed. However, we will be completing the Phase III clinical trials that are already underway.
- The FDA continues to reassess the safety requirements of clinical trials of anti-infectives, specifically ketolides. Abbott is taking into consideration concerns regarding QT with the ketolide class and is conducting a QT study. Additionally, we are waiting on analysis of additional Phase III data.
- At this time, since we have missed most of this respiratory season, our trials will be delayed. We do not expect QT to be an issue with ABT-773. However, it is prudent to have the QT study completed before we move forward with the Phase III trials.
- We will keep you apprised as to our Phase III development plans/timeline.
- You will receive a letter and/or phone call once the development timeline for ABT-773 has been determined. [If asked specifically: the timeline for ABT-773 has been pushed back one year].

ABT-773 Headcount Rollout
[DATE]

ABT-773 WORKLOAD DEMAND

Clinical														
Venture	39.5	36	33	31.5	29.5	25.5	24.5	23.5	18.5	15.5	12	9	9	22.5
DM/Stats	30	30	30	24	20	18	12	8	4	4	2	2	0	12.8
Europe	6	6	6	6	5	5	2	2	1	0	0	0	0	2.8
Phase I	9	9	9	9	5	5	2	0	0	0	0	0	0	3.3
CMC														
PARD	26.4	26.4	26.4	18	10	7	6	5	3	1	0.5	0	0	6.8
Process RAD														
R430 Chemists	12	14	14	4	4	4	0	0	0	0	0	0	0	3.7
FAST QSPD Analytical	6	6	6	3	3	3	0	0	0	0	0	0	0	2.3
SPD Tech Ops	2	2	2	0	0	0	0	0	0	0	0	0	0	0.0
Drug Safety	10	6	6	4	2	2	2	1	0	0	0	0	0	2.1
Other														
Discovery	10	10	8	8	8	8	4	4	0	0	0	0	0	4.0
Other (RGA, Reg, Med Aff)	5	5	5	5	5	4	4	0	0	0	0	0	0	3.0
Total FTE on 773 by Month	162.8	167.4	162.4	111.5	92.5	79.5	63.6	44.5	27.5	20.5	14.5	11	9	65.5

HEADCOUNT REALLOCATION

Venture (no issues)

With 482 ramp-up, some specific transfers already requested, expiring contracts, and 22 openings currently available no issues likely. First placements in 3Q.

DM/Stats (no issues)

Area currently significantly over-absorbed, currently 11 openings for area and substantial contract population.

European team (no issues)

Transfer already in place for EVR to ECO transfer.

Phase I (no issues)

Currently under-absorbed with 4 openings in area. Unit bed utilization with 492 possible.

PARD (possible issues)

Necessary workload demand is less than indicated (20 FTE months or 1.6 FTE, for year further savings possible). Staffing purposely been left intact to April, to be consistent with message. Although 11 HC open most positions in Ludwigshafen. Needs further discussion.

R430 chemists (issues)

5 open headcount for new expected DDC products in Q2. Further absorption if Knoll endothelin antagonist deal materializes. Specific discussion with manager needed.

FAST rapid analytical (no issues)

Immediate absorption possible on new Abbottasee needs.

SPD Tech (no issues)

Only reflected as upside in SPD plan.

Drug safety (no issues)

Heavily over-absorbed with 17 current openings

Discovery (possible issues)

Specifically microbiology impact. Units in 482 can absorb, but 3-4 people with specific skill sets might be affected.

Other (no issues)

Confidential

ABBT225322

ABT-773 Headcount Rollout
[DATE]

Most areas less than 1 FTE with most having current openings.

Confidential

ABB7225323

Deposition Exhibit 53

P's Exhibit NE

John M
Leonard/LAKE/PPRD/ABBO
TT
04/15/2002 06:10 PM

To: Thomas J Lyons/LAKE/PPRD/ABBOTT@ABBOTT, Stan
Bukofzer/LAKE/PPRD/ABBOTT@ABBOTT
cc:
bcc:
Subject Re:

The Hancock response that Jeff wants:

John M. Leonard, M.D.
Vice President
Global Pharmaceutical Drug Development
Global Pharmaceutical Research and Development
PH: (847) 938-4545
FX: (847) 937-3918
Vickie Enders, Admin. (847-935-1905)
— Forwarded by John M Leonard/LAKE/PPRD/ABBOTT on 04/15/2002 06:10 PM —

Jeff M Leiden
04/15/2002 04:39 PM

To: John M Leonard/LAKE/PPRD/ABBOTT@ABBOTT
cc:
Subject Re: ☐

I think we should tell them that we are

1. reviewing the Ketek situation re size of safety database
2. Carrying out additional ph I studies of QT and hepatotoxicity at request of FDA to assess class effects of Ketolides
3. Analyzing existing phII and phIII results for impact on label and market opportunity

That we expect this analysis to be complete by June July and at that point we will be in a position to make a decision on if and how to proceed with additional phIII development
We will keep them in the loop as our analysis proceeds

Jeff

Jeffrey M. Leiden MD PhD
President and Chief Operating Officer, Pharmaceuticals
Chief Scientific Officer
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John M Leonard

John M Leonard

To: Jeff M Leiden/LAKE/CORP/ABBOTT@ABBOTT
cc:

Confidential

ABBT225709

Leiden EXHIBIT 53
FOR I.D. _____

04/15/02 07:55 AM

Subject:

Two quickies: In case you did not hear it, we were cleared by FDA to enter women in all the .695 studies so we are back where we wanted to be.

Second, and more important, we own Hancock an update. How do you want to handle the 773 communication? We can say that we are analyzing data and have slowed down(as we have been saying externally), but if the questioning goes deeper, we will need a plan as the status will evolve quickly.
J

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ABBT225710